

# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## *Now We Are at War*

THE United States is at war, a war not of its own choosing but one forced upon it by attacks from outside powers. The first result of these attacks is that the people of the United States as never before in their history are united to win the war in order to preserve and strengthen the democratic way of life—with its goal of a better life for all the people.

In this crisis nurses like all loyal citizens will do their part. First call upon nurse power of the country will be service in the Army and Navy Nurse Corps, and nurses in increasing numbers are enrolling with the American Red Cross for military service now that war has started. Doubtless some of these will be public health nurses.

No less important is nursing service to help maintain the health of our civilian population, of the workers who supply the equipment for the military forces, of the mothers and the children upon whom the future of the country depends. Service to the civilian population—less dramatic but no less necessary than military service—is the work for which perhaps most public health nurses will be needed. Most of them can probably make their best contribution by working at their old job a little harder, trying to do it a little better and more completely, keeping themselves and their programs flexible for new defense demands and emphases.

In addition, each can undertake something outside her regular work. She can take a first-aid course to be ready when needed, teach a home nursing class, secure a recruit for a nursing school; in brief, do the extra things needed in her community for which her nursing background has prepared her. The definite steps which every nurse can take to participate in the defense program of her own community are listed in an article, "Your Part in Civilian Defense," by Marian G. Randall, on page 22.

As they concentrate on these duties nurses can have confidence that the vast resources of this country and the determination of its people will bring victory in the end. They can be proud that they have special skills to offer which are much needed now. Hard work and sacrifice will be necessary. But they can be assured that their efforts will strengthen the courage and morale as well as contribute to the physical well-being of those they serve. Best of all, they can have the satisfaction, as health workers, that the results of their endeavors will continue beyond this emergency and will contribute to the permanent welfare of the people after the war is over. They can do their bit toward winning the war and at the same time help to "win the peace."

RUTH HOULTON, R.N.

*General Director, National  
Organization for Public Health Nursing*



## Membership Helps You!

TODAY MORE than ever before, the public health nurses of this country need their national organization for guidance in the trying days that are ahead of us. Planning on a nationwide basis is necessary to assure adequate nursing care of our armed forces and our people in communities everywhere. Public health nurses want direct representation on all groups which are planning programs and policies which concern them.

Today as in 1917, nurses are eager "to give every possible support and coöperation, in unswerving loyalty to those upon whose shoulders so heavy a burden of responsibility is laid."

While we are very proud of the membership record which has been set in 1941, the present emergency demands redoubling of our efforts. The year 1942 must bring an ever larger number of new members—both nurse and lay—because every public health nurse needs all available help in serving her community and her country, and the national organization needs their support.

The many letters of appreciation and verbal reports to the N.O.P.H.N. tell vividly of specific ways in which the National is useful to its members. These letters were the inspiration for our 1942 membership slogan: "Join the N.O.P.H.N.—Membership Helps You!"

Miss Fillmore, who until very recently was a staff nurse carrying her bag on the district, writes to tell us how membership helps her. Other letters from our members far and wide in different fields of work will be shared with you in succeeding issues.

**AMELIA GRANT, R.N.**

*Chairman, National Membership Committee*

A NURSING professor in California first told me of the N.O.P.H.N., saying, "Write for help if you need it."

Not long afterward—a scared young nurse in a rural county, with no possibility of supervision—I tried out the suggestion. I had organized a county nursing committee. The members were energetic. I was busy. What could I do with them now that I had them?

A hurried appeal for advice was answered promptly. Many times that winter I asked, and each time my needs were met. In this remote area where not one other person spoke "my language," the N.O.P.H.N. became my colleague. The current issue of PUBLIC HEALTH NURSING jogged about the countryside tucked in between boxes of records, eye charts, baby scales, and lunch so that an unexpected wait in the mud while a farmer came to pull me out wouldn't find me napping.

Now, working in one of the biggest and most complex cities in the world, in a well developed organization, with excellent supervision and the stimulation of quick-witted colleagues, I still turn to the N.O.P.H.N. and find help. What's happening to public health nurses in the defense program? What is the rest of the country doing about staff-education programs? Has any one tried a standard budget to help in fee collection?

As I opened my PUBLIC HEALTH NURSING November first and found the excellent article by Miss Bowes on "Sharing the Newer Knowledge of Nutrition," I thought once more, "No, I couldn't do without N.O.P.H.N."

**ANNA FILLMORE, R.N.**

*Assistant Supervisor, East Harlem Center,  
Henry Street Visiting Nurse Service,  
New York, New York*

## QUALIFICATIONS REPRESENT GROUP THINKING

THE SUBCOMMITTEE\* which has prepared the recommended qualifications for public health nursing personnel for the period 1940-1945 takes pride in presenting this new statement, published on page 24. These revised qualifications are the work of ten different groups and over a hundred nurses representing all parts of the country. Hence, we believe that they truly represent countrywide opinion. It is interesting that with the exception of added recommendations for two new groups of workers—nursing consultants in the special fields and directors of university programs of study in public health nursing—so few changes seemed necessary. We believe this indicates the clear and wise thinking that went into the previous revisions and the growing unity of thought in regard to the requirements for personnel in this field.

These recommended qualifications are intended as a guide to employers in appointing new members of their staffs for the next five years. They are not to be considered mandatory or retroactive, nor should a nurse with many years of

high quality service feel that the value of that experience is not appreciated. Many who worked on these qualifications have not themselves enjoyed the advantage of the specified preparation for the various positions as outlined in the recommendations. In fact, the academic preparation and varied experience under competent supervision as described here have not always been available. On the other hand, public health nursing was less complicated and less exacting in its demands in earlier days than it is today.

We hope these recommendations will stimulate thoughtful discussion and stock-taking by public health nurses everywhere and that they may in many instances serve to reinforce current efforts to secure an increasingly high quality of work in local communities.

LEAH BLAISDELL, R.N.  
*Chairman, Subcommittee*

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\* Subcommittee for the Revision of Minimum Qualifications for Nurses Appointed to Positions in Public Health Nursing for the Period 1940-1945 of the Education Committee of the National Organization for Public Health Nursing.

## TWO IMPORTANT STATEMENTS

IN THIS CRISIS, the close cooperation of all agencies concerned with meeting the nursing needs of the nation is vital. Especially encouraging, therefore, are two recent evidences of the mutual understanding and cooperation of the professional nursing groups and the Office of Civilian Defense. A splendid article in the December *American Journal of Nursing* by Dr. George Baehr, chief medical officer of the OCD, emphasizes the necessity for safeguarding the standards of professional nursing in

order to ensure protection of the public. And the following statement was issued on November 15, 1941, by the Nursing Council on National Defense, which represents the four professional nursing organizations:

During the emergency, the Nursing Council on National Defense is cooperating to the fullest possible extent with the American Red Cross and the U. S. Office of Civilian Defense in augmenting nursing services through the Voluntary Nurse's Aide Program. It is believed that by so doing the standards of professional nursing, as represented by the Council, can best be safeguarded.

# Private Agency in the Defense Program

By KATHARINE FAVILLE, R.N.

**Does the private nursing agency have a real contribution to make today? Can it justify the employment of nurses when the demand for them is so great elsewhere?**

**F**OR MANY YEARS the program of the private public health nursing agency has gone on practically unchallenged. It has had the strong support of leading citizens. Its program has remained the same. Major changes have been few. Recently, however, public funds for support of public health have become increasingly available, not only to expand service into areas hitherto unserved, but to expand the official agency program itself. In some localities consideration is being given to the possibility of the public agency taking on the bedside nursing service—the traditional province of the private group—in order that only one nurse will serve the family. The need of a private nursing agency as a separate entity is being seriously questioned in such places.

Coupled with this shift of program comes the demand for nurses by state and federal governments; and in some of our large cities such an apparent shortage of nurses has developed that many agencies and institutions are finding it decidedly difficult to staff their units. Most nurse administrators are noticing an increasing unrest among the members of their staffs—particularly in the private agency.

In the face of this situation it is well that we ask ourselves what the function of the private agency is today. Does it have a real contribution to make to the defense program as well as to community health, which justifies its demands on the contributor—who in addition to

facing greatly increased taxes is besieged on all sides for contributions to a multitude of worthy causes? Can it justify the employment of nurses when the demand for them is so great elsewhere?

## FUNCTIONS OF PRIVATE AGENCY

In the past we have stated our functions as follows:

1. To supplement but not duplicate the service of the official agency, working under its leadership and planning with it on a community basis. In most communities this has meant chiefly a program of bedside care, with a varying amount of health supervision of individuals or families, selected usually from a morbidity service intake.
2. To use the service for field experience for students of public health nursing. Most large private agencies have considered the preparation of students as secondary only to their community service program.
3. To study and develop new methods and services, since private administration gives flexibility to the use of funds.
4. To develop a lay public that is educated, through active participation in the service, to an appreciation of the values of public health, so that it will work for the maintenance of community service adequate both in quality and quantity.

These functions are time-honored in theory, but actual practice has seldom measured up to them. Too frequently we of the private agencies have felt that official leadership was not of a quality which deserved our coöperation, and instead of working to improve it we have sought many times to take over activities it should perform. We have only ourselves to blame if in some communities

today, as the public agency has come to be more financially secure the private agency is looked upon with suspicion, as of doubtful value; and the contributions which we see ourselves able to make are regarded without great enthusiasm.

In the light of the present situation, these functions of the private agency will be discussed separately.

#### THE SERVICE PROGRAM

For many years the National Organization for Public Health Nursing and the American Public Health Association have stated that in any one area there is usually need for only one public and one private public health nursing agency. The defense program would seem to demand from each of us stringent economy and to require each community to make community self-evaluation and planning its first duty. Whether the initial request for this comes from the official or the nonofficial group is of far less importance than that the effort be sincerely made. When wise leadership and professional integrity are present and agency prerogatives submerged, relative values as to service needs are readily recognized, and the precedence of basic needs over "frills" is insisted upon. Luxury service will not be allowed to absorb nursing time, even though income from well invested funds is available for that purpose, until all essential professional needs are met throughout the country. The first obligation of every private agency today in the defense program, therefore, is to promote such a community study and to insure a wise, economical use of nurse power.

Our second obligation arises out of this. Having merged our private agencies, at least, into one administrative unit in each area, we have a tremendous need to study details of the service itself; and with the health department and all other groups concerned, to determine the order of importance of service needs and how they shall be met. Such joint plan-

ning on a community basis will in most areas show that many of the unmet needs arise from a lack of just this type of community planning and can be met much more adequately with the same staff if an inclusive, over-all plan is developed. For the visiting nurse service this will mean a review of its entire intake policy in the light of local morbidity and mortality statistics, and will in most communities show a need for at least three definite developments if the community is to be well nursed and nurse power conserved.

#### *Coördination of hospital and home care*

First is the need to tie hospital and home nursing care together into a co-ordinated unit through carefully worked out written coöperative agreements, by which certain types of patients will be automatically referred to the visiting nurse service with medical orders for home follow-up. In New York City a plan has been developed under the leadership of the Department of Health, which calls at present for referral of clinic patients of the following types: antepartum patients, premature infants and those in the neonatal period, rheumatic fever patients, and other children with cardiac conditions while convalescing at home. Other types will be included as our study progresses. Under this plan the visiting nurse service makes one visit to each patient reported and on that basis selects patients most in need of further care. Its health supervision load is drawn, therefore, not alone from its morbidity service, but from those types of patients for which local vital statistics show the greatest need for service.

Since in New York City the indigent sick secure medical care largely from the hospitals and clinics, no plan for selection can be made except as hospitals and their medical directors are brought into it actively. So long as the private agency serves only those who know how to ask

for care, and does not go out after the patients who most need that care, it can not claim to be administering its service as a public health agency. The amount of free work that the various visiting nurse services throughout the country can do differs considerably, but the need for constant re-examination of intake policies, so that the free work done will most effectively meet public health needs, is evident.

#### *Care for middle-income group*

Second, a study of the community public health nursing program will in most instances show that the middle-income group of citizens sadly lack nursing care when ill at home. Usually they neither need nor can they afford full-time nursing service. Frequently, however, these patients do not understand the use of the part-time pay service that the visiting nurse service has to offer, and an active promotion program is needed, at least in the larger cities. This involves a carefully worked out plan with both the hospitals—the semi-private and private services—and the organized nursing groups. In New York City, we have found a great need for home care following discharge from hospitals for the semi-private group who carry hospital insurance, and who are almost entirely unknown to social service. While these patients have met their hospital costs through insurance, their medical bills often mount to a disastrous sum, and the need for guidance in budgetary planning is frequently second only to actual nursing care needs.

At the Henry Street Visiting Nurse Service the part- and full-pay service in the last year has increased 30 percent and we are making great effort to give it wide publicity and adjust administratively to its demands in various ways, such as extending service into the evening. As might have been expected, we are finding the need for intelligent nursing as great here as in some of the less

privileged homes. Care must be taken to see that this service does not encroach on the free service, however. This necessitates clear thinking by the board of directors and a recognition of two separate divisions in the budget—that for free care limited by the contributions secured for free work, and that for paid care adjusted to the fees received. Service by nurses is generalized, but growth of each service, speaking from a budgetary standpoint, is governed by different factors.

#### *Service to industries*

Having seen to it that the intake policies are based on an intelligent community plan, statistically guided and economically administered, the private agencies in many sections of the country will be needed in addition to supplement official efforts in safeguarding the health of the industrial worker. It is expected that the department of health will study industrial health needs and supply an advisory personnel which will assist local industries in the development of health services. In industries having defense contracts pressure is already great, the incidence of accidents and illness is increasing, and employers are eager to do all that is possible to keep employees at work. Well qualified public health nurses are needed for such services and the private agency can make a real contribution by preparing and then freeing its own staff nurses for such work. In the case of small industries that can not afford or do not need the full-time services of a nurse, the agency can consistently sell service on an hourly basis at cost. A number of communities have already begun to offer such a program to industry and the sale of nursing service by visiting nurse associations is slowly growing.

In New York City, with the approval of the health commissioner, the Henry Street Visiting Nurse Service sells such service to the plant at cost, and its



nurses are finding the opportunities for health instruction so real that they are grateful for the privilege thus afforded. In addition, requests from employers for contracts with the nursing agency to care for employees when sick at home are increasing rapidly, necessitating a real effort in our staff-education program to strengthen the content of our adult health supervision visits. About one thousand such contracts, either direct or through group insurance, are in force at present in the Henry Street Service.

So in this emergency, we still adhere to our first historical function, that of supplementing but not duplicating the official agency's program, taking pride in being a necessary part of the community plan—respected, we hope, by our co-workers because our sense of values is guided by a public health knowledge of community needs, and not by agency consciousness.

#### PROFESSIONAL EDUCATION PROGRAM

Although at all times the private agency has afforded valuable field experience for inexperienced public health nurses, perhaps there has never been as great a need to supply it to such large numbers of new workers as there is at present. When this summer the United States Public Health Service decided to employ over a hundred nurses, it was the private agencies that largely furnished this personnel—and rightly so. For over the country as a whole the public agencies have need of every experienced staff member if essential community services are to be maintained. If inexperienced nurses must be employed immediately for replacement they can probably be assimilated more rapidly and effectively by the private group with its bedside program and long experience in training than by the average public agency. Moreover, if we as a group believe in public support for health work, we should care intensely that the highest

possible civil service standards be maintained, and be ready to make any sacrifice necessary to assist in recruiting a well qualified personnel.

Since defense industries and extracantonment zones represent the most difficult types of pioneer services, we must plan to release experienced staff members. There is no place here for the poorly adjusted, inexperienced, restless nurse and we have as definite a responsibility to keep her from applying as we have to urge the right type of nurse to go.

At the Henry Street Visiting Nurse Service, the Nursing Committee and Board of Directors recognized this and approved a plan involving the following steps:

1. A plan was to be developed to release the maximum possible number of experienced nurses for government service and still maintain a satisfactory quality of service locally. This involved a study with each staff member of her stage of development and a mutual recognition of her individual place in the plan. It was decided that those released to the government should have had at least three years of supervised experience, should have completed a year's study in public health nursing theory, and should be mature, well adjusted, dependable workers. It was considered equally important to select those who would remain in the organization to carry the service load and continue actively with their preparation, while assisting with the induction of our increased number of trainees. It was thought that a maximum turnover of 100 nurses could be handled each year so long as the emergency exists, which just doubles the usual rate.

2. The plan next calls for enlargement of the recruiting and staff development program so that replacement with a basically sound young group will be assured and the quality



and quantity of community service be maintained.

3. Provision of additional funds is necessary so that the community service program can be kept stable. It was recognized that an inexperienced staff nurse during her first year of service with us is only about 80 percent as effective as a nurse in her second and third years. Therefore, every five seasoned nurses who leave are to be replaced with six new ones, with supervisory and clerical service increased in proportion. Believing that this is a real contribution to the defense program—for no program is any stronger than the caliber of its staff—the Board of Directors voted to meet this increased cost from capital funds, if necessary. Such expenditures will be separated from current running expenses, and studied as to their effect on visit costs.

It was agreed that insofar as possible, staff would be released under this plan *only* for defense purposes and to those sections of the country which, through lack of professional personnel, are themselves unable to provide workers for their increased needs. This involves discouraging our staff from taking positions with certain types of agencies which are not carrying essential services, or from going to communities where there is no conscious effort to avoid duplication and to use economically the nurses already available locally. In the first few months of this plan we have released 22 on a leave of absence for defense work, and many others regard themselves as on call.

The success of such a plan, however, depends on the complete coöperation of the entire staff, so that each member settles down, recognizes her function in the agency as a teacher of the new group and a stabilizer of the service, and accepts the necessity for growing up in public health as rapidly as possible. If quality service is to be maintained

locally it means a double responsibility for each supervisor, who sometimes has to be helped to see that her contribution to the national defense program will be as great if she remains to assist in the training program as if she herself volunteers for the greener fields that are calling. Upon the administrative group devolves the difficult problem of keeping the group steady and of maintaining a sense of proportion. To speak realistically, however, we were faced early in 1941 with restlessness and an increased turnover anyway, and the plan described has been our answer to the question of whether we would try to guide this constructively, or have a turnover of inadequately prepared workers that upset our local service but contributed little to the total defense need. Only time can prove or disprove its wisdom.

In the discussion of any program of field experience it seems fitting to remind ourselves that the contribution which a private agency is able to make is directly related to the order which that agency has brought to its own house. For its value as an experience for new staff surely is small unless the nurses who work there see a community program functioning properly and the private agency's work effectively integrated into it. For too many years private agencies have emphasized in their training programs perfection of technique and routine methods of work, to the neglect of development of a worker who could plan for herself, possessing a sense of relative community and professional values as to what must come first in a crowded program. Too often the staff nurse saw expressed in the attitude of her administrative superiors a feeling that the official program, personnel, and performance were weak, and too seldom did she see in action a generous aggressiveness attempting to inculcate leadership where it rightfully belonged if it did not already exist there. Nurses do not

learn coöperation and community planning by hearing it discussed in the classroom. Rather, they learn it by seeing it functioning in actual practice in the community.

#### STUDY OF NEW METHODS

With a shortage of experienced public health nurses and a conviction that nurse power must be conserved for nursing needs, we face today the urgent question of the place of other workers in our program—of the practical nurse, the nurse's aide, and the slightly trained volunteer. Where and how can they be used without jeopardy to the safety of the patient? Must every visit now made by a public health nurse be a public health visit? If not, at what spot must service be picked up again by the public health nurse? Certainly, there are no definite *types* of patients who can be turned over to the nonprofessional group—such as the chronic or the convalescent patient—for we know how conditions within each family change. Because our bedside care program lends itself to such experimentation, we have a challenge to try out new ways by which we can conserve our supply of professional nursing through every possible use of other workers.

This next winter should see us actively engaged in such studies. We must admit at the outset that our standardized picture will be greatly changed and perhaps the cost of visit increased. For if many of the more routine visits are removed from the nurse's day, will not the remaining visits be longer and will not the time required for making contacts with physicians, for referring to social agencies, and for record-writing increase? What of the cost of supervision? No one knows the answer at present, but no one will deny both the importance of the problem and its complexity, and the necessity that the answer found shall fit correctly into our total future plan for community nursing.

#### EDUCATION OF THE LAY PUBLIC

In regard to our fourth historical function—that of educating a lay group to understand and support public health programs—the present situation offers a good test of the success of our past efforts.

Because of the lay workers' control of the private agency through fund-raising and actual administrative participation, we have always claimed that their opportunities to learn sound public health principles and practice were greater in the private agency than in the public agency. Today we public health nurses in private agencies can well ask ourselves what we have taught our lay committees and board members, and question how they are going to rise to the emergency that faces us. Can they pull their weight in this need for changing our pattern? Do they know and believe in good administrative practice so that in some instances they will even force our steps, when reluctant, into the paths of community coöperation? Here is our chance to learn whether we really prepared them for this broader field of community service and to evaluate our own philosophy in terms of their action.

So, in summarizing, we maintain that for each private agency, in each community, the first step in finding its place in the defense program consists in bringing about a community evaluation of the total public health nursing program, so that we conserve our supply of personnel and are able not only to provide for present needs but to maintain high professional standards as defense programs expand.

Never were we as a group faced with a greater challenge and our success may be evidenced in great part by the degree to which the coming months bring an actual reduction in the number of private agencies through merging of community groups. Appraisal at a future date should show that, following this movement a strengthening of pro-

grams resulted because of an increase in funds released for community service through a saving in administrative costs, as well as a freeing of personnel for expansion into areas sorely in need of the public health nurse. Unfortunately, there is much more to be done than there are qualified workers available to do it, and a sound administrative policy must be developed to make the best use of every member of our profession. To attain this in practice throughout the stretch of this country is the most important job of the private as well as the public agency at present. There is no need to change fundamental professional principles. The need is to

make practice, long reluctant, more consistent with these principles.

It is time that each of us pauses and remembers that we are first of all public health—not agency—workers, and that as a group we stand together, regardless of the type of our employment, firm in our belief in the contribution which our profession can make to human welfare, and convinced that teamwork is more highly prized as our tool than is any skill symbolized by the time-honored black bag.

Presented before the Public Health Nursing Session, Annual Meeting, American Public Health Association, Atlantic City, New Jersey, October 16, 1941. Published in the *American Journal of Public Health*, January 1942.

## Lay People Build a Four-Town Service

**L**AY PEOPLE can do it! The ability of the people in a community to build a health service which meets their needs is shown by the development in one year of a four-town nursing service in a New York area, through the leadership and active participation of lay groups.

In August 1940, a public health nurse was assigned to a four-town area by the Onondaga County Public Health Committee which has been officially appointed by the Board of Supervisors to administer public health nursing in Onondaga County. This area—comprised of the four towns of Fabius, La Fayette, Otisco, and Tully—was selected because the total population was approximately 5000, a number which New York State considers a public health nurse can serve with reasonable effectiveness. Moreover, these four towns had previously shown unusual civic interest and leadership in health matters.

One of the towns, Tully—which is

equidistant from the other towns—was selected as the headquarters of the area. Here a health center consisting of a meeting room and a clinic room was established. Expenses for rent, telephone, and furnishings were paid jointly by the four-town boards. The health center held a very successful open house, at which 110 visitors signed the guest book.

An organization meeting was held shortly after the health center was acquired. Representatives from the four towns attended. At this time a chairman for the entire area was elected and a plan to organize in each of the towns a lay committee headed by its own town chairman was decided upon.

Eight residents in each town were visited by the newly elected four-town chairman. The objectives of the work were explained and those who were willing to assist in carrying on public health work in their own community were asked to meet and organize as a

lay group. The purposes of the lay groups are: (1) to assist the public health nurse in establishing and carrying on projects to meet the needs in each community (2) to determine through observation new health needs that arise from time to time and to decide how these can best be met by coöperating with the nurse and the health officials.

The members of each township group elected their own town chairman. They also volunteered to become co-chairmen in charge of the types of health work which appealed to their respective interests. These co-chairmen were in turn to select a sufficient number of lay workers to carry on suggested projects efficiently. The lay groups, numbering from three to six according to the project on which they were to work, were chosen from all sections of the townships. In this way a large number of women spread over a wide area are engaged in public health work.

The projects which were developed through the coöperation of the lay workers with the public health nurse include the organization of well baby and pre-school health services and mothers' clubs, the establishment of loan closets, the making of obstetrical bundles and layettes, plans for the transportation of patients to clinics, and organization of publicity committees and committees to inform the nurse of family needs and problems. In addition, a committee in the headquarters town shopped for furnishings for the meeting and clinic rooms, made slip covers for second-hand furniture, prepared health posters, and succeeded in preparing an efficient and attractive health center.

The quarterly reports from the four towns show that the lay groups are functioning very well. Transportation committees have brought babies and pre-

school children to child health conferences, where volunteer workers have assisted by weighing and measuring the children and by recording. A supply of layettes has been made, from which the public health nurse draws whenever the need occurs. Three of the towns are still working on their loan closets. One already has a well equipped closet. These are centrally located in each town in a home where admittance is possible at any time.

The publicity committees have placed health news of local interest in the town papers, have telephoned plans for health activities, and have announced clinics and health events at local meetings. A scrapbook of all events has been kept. In one town a group of expectant mothers was organized into a class on antepartum care, with such success that the mothers are now requesting a follow-up course in child training. A sewing committee in another town made 14 examination gowns to be used jointly for physical examinations at the health center and at their school. Lay committee workers have also assisted at local immunization clinics and chest clinics. At present, committees are coöperating with leaders in defense work by organizing groups for classes in home nursing and first aid.

In the four-town area during a year of lay organization, public health work has progressed most satisfactorily. Knitted together by organization and coöperation, the people of the area are experiencing the effects of public health standards raised through their efforts in assisting their local public health nurse and their health officers.

MRS. WILLIAM KEARNS

*Chairman, Four-Town Health Center  
Committee, Tully, New York*

# Leading the Fight on Poliomyelitis

By BASIL O'CONNOR

**The broad program of the National Foundation for Infantile Paralysis covers the entire field of the cause, prevention, and amelioration of the disease**

**T**HE WHOLE field of infantile paralysis still presents many unsolved problems. It was to lead, direct, and unify the fight on every phase of this sickness that the National Foundation for Infantile Paralysis, Inc., was organized on January 3, 1938 as a non-profit membership organization.

Active management of the affairs of the Foundation is vested in a Board of Trustees consisting of 34 representative men from all parts of the United States. The Board is permitted under the Foundation's by-laws to elect corporate officers, appoint committees, delegate power, make grants and donations, and take such other actions as naturally arise in the course of administration.

From the beginning it was fully realized that since the Foundation's work was essentially one of medical science, allotments of money for carrying on the national fight against the disease should be made with the advice of a General Advisory Committee. This Committee consists of 12 outstanding doctors familiar with the problems in this field. Under the general committee are six special advisory committees composed of physicians qualified in their separate fields, who advise on grants for scientific research and education, and counsel the Foundation on its medical program. These committees, which indicate the scope of the Foundation's medical interests, are: Committee on Virus Research, Committee on Research for the Prevention and Treatment of

After-Effects, Committee on Nutritional Research, Committee on Epidemics and Public Health, Committee on Medical Publications, and Committee on Education. Other committees, composed of trustees, which deal with organization activities, are the Executive Committee, the Finance Committee, and the Committee on Chapters. The Foundation employs a full-time medical director, an executive secretary, and a director of information.

## WHAT THE FOUNDATION DOES

The National Foundation offers, for the first time in the history of this disease, an opportunity not only for coordinated service but for continuity of work over whatever period of time may be necessary. Heretofore research on infantile paralysis has been largely dependent on sporadic or temporary grants. Temporary assistance may help the research worker but unless he is enabled to complete his work the cause is not benefited.

The procedure followed by the National Foundation is designed to bring into clearer relief the real problems and the best methods to be used for their possible solution. To discover, coordinate, and disseminate knowledge of the cause of infantile paralysis, how it may be prevented, and how its after-effects may be ameliorated is at best a most difficult undertaking. It is, however, the task which the Foundation has set itself to do.

When the National Foundation was



Basil O'Connor, president  
of the National Foundation  
for Infantile Paralysis



*Photo by Bachrach*

organized in January 1938, its activities were to be confined primarily to assisting in study and research on the medical problem of the disease as a whole and not to rendering direct individual care to those afflicted. In the early part of 1939, however, the demands for direct aid for individual patients throughout the United States became so great that the Foundation found it necessary to organize local Chapters in the various counties of the United States in which a part of the funds raised by it each year would be left for direct local relief. It was believed that through these county Chapters a still further consolidation and unification of all the forces necessary for the attack on the whole front line of the disease would take place.

The Foundation's task in attempting to conquer infantile paralysis and to lessen its effects has fallen into two main divisions, local and national.

Each Chapter of the National

Foundation is organized according to a carefully prepared Manual for Chapters, and the administration of its affairs is under the supervision of the National Foundation. Fifty percent of the funds raised in the annual Celebration of the President's Birthday remains in the county to be expended by the Chapter. The Chapter is advised to avoid duplicating either the work being done by the National Foundation itself, or the work done by other already existing local agencies. Funds of the county Chapter may be used for direct assistance to those afflicted with poliomyelitis, irrespective of age. Other activities include keeping the public regularly informed of all local and national infantile paralysis activities and sending to the National Foundation annual financial and activity reports. During recent epidemics, well organized local Chapters in coöperation with the medical profession and public health officers in



charge rendered splendid assistance to those afflicted. The services given by Chapters are most effective when correlated with those of other agencies in the community.

#### BROAD NATIONAL ACTIVITIES

The Foundation's aim in national activities has been to do the kind of work that will benefit not only particular individuals but all afflicted with this disease. Generally speaking, it has acted thus far as a grant-making agency. It has not engaged directly in scientific research.

All grants-in-aid are made with the approval of the medical advisers. As a general rule, accepted projects receive grants on a budgetary basis for a one-year period. Renewals are considered in ample time to assure the uninterrupted progress of activities continuing over a period of years. Grants have been made for virus research, nutritional research, after-effects research, epidemic aid, and education.

#### *Virus research*

Virus research is being carried on in universities, hospitals, and research foundations. Efforts are being made to learn more about the virus—where it occurs in nature, how it leaves the body, and how it gains entrance to the body of its next victim. Attempts are also being made to find a way of preventing the disease or to find a drug capable of killing the virus within the body. Other problems receiving intensive study are immunity and resistance to the infection, and changes in the cell structure of the body as a result of the invasion of the virus.

#### *Nutritional research*

Since there has been little information concerning the relation of nutrition to virus diseases such as infantile paralysis, the Foundation has taken the lead in attacking this problem. Efforts are not limited to the relation of nutrition to poliomyelitis but encompass the entire

field of communicable diseases. This broad approach is considered desirable not only for the general possible good that may result, but so that certain tools and methods of investigation may be developed in the study of the whole problem before an approach is made to the highly specialized field.

#### *After-effects research*

Existing methods of treatment are being studied and evaluated. Some of the problems which are receiving attention are: When should the treatment start and how long should it continue? What are the advantages of long-continued hospitalization as against intermittent hospital care? What are the benefits of underwater treatment as compared to table treatment? How important a part does rest play in the after-treatment? What causes atrophy in muscles? The entire problem of the manufacture and use of braces is also receiving careful attention. It is hoped that these studies will result in supplying more efficient, more durable, and less expensive appliances in the future.

#### *Epidemics*

The Foundation has assisted in epidemics in several ways: aiding or conducting epidemiological studies in the area of the epidemic; giving emergency assistance during the epidemic; supplying equipment such as Toronto splints and Bradford frames; arranging for respirators; and securing additional personnel such as nurses trained in the care of this disease.

#### *Education*

Activities in this field have been increased and expanded. Education as used here includes not only disseminating information to the public, but also developing strength in the fundamental medical approach to the problem in places where lack of funds has caused weakness.

Recognizing that good nursing is im-

portant in treating properly the after-effects of poliomyelitis and other crippling diseases, the Foundation has made several grants to make possible better preparation for nurses in this field.

Three annual grants and one supplementary grant have been made to the National Organization for Public Health Nursing for the purposes of: (1) encouraging nurses with desirable qualifications to prepare themselves for the field of orthopedic public health nursing (2) stimulating accredited colleges and institutions to install centers where nurses can be sent to practice orthopedic nursing under supervision (3) preparing a manual on orthopedic nursing care. In 1940 the Foundation granted funds for seven scholarships to prepare public health nurses for teaching and supervisory positions in orthopedic nursing. This grant was renewed in 1941.

A grant was made to the National League of Nursing Education in 1941 for the purpose of establishing a joint orthopedic nursing advisory service with the N.O.P.H.N. This grant is being used for the appointment to the League staff of a graduate nurse who is a specialist in orthopedic nursing to work with the consultant in orthopedic nursing on the N.O.P.H.N. staff. (See *PUBLIC HEALTH NURSING*, October 1941, page 610.) Scholarships to prepare nurses for teaching and supervisory positions in schools of nursing are also provided. This joint advisory service should have far-reaching effects in strengthening orthopedic nursing in schools of nursing and in all nursing services in hospitals, clinics, industries, schools, and homes.

To make available proper courses where nurses may secure special preparation in orthopedic nursing, the Foundation has made grants to Teachers College, Columbia University; Western Reserve University; and the University of Minnesota.

Several pamphlets prepared, pub-

lished, and distributed by the Foundation through the use of its educational funds are of particular interest to nurses. Copies of these are available without cost:

Gudakunst, Don W., M.D. *Doctor . . . What Can I Do?* (A summary of information describing what is known of the symptoms, cause, means of spread, and prevention of poliomyelitis.)

Stevenson, Jessie L. *The Nursing Care of Patients with Infantile Paralysis.*

O'Connor, Basil. *The Conquest of Infantile Paralysis.* (An address delivered at the Foundation's first annual medical meeting.)

Splints—*Their Distribution and Use.* (A description of splints used in the treatment of poliomyelitis with instructions for their use.)

Wilson, James L., M.D. *The Use of the Respirator in Poliomyelitis.* (Facts concerning the use of the respirator, or "iron lung," in the treatment of poliomyelitis.)

Respirators—*Locations and Owners.* (A list of adult cabinet type respirators available throughout the United States as of July 1, 1941. It contains only those approved by the Council on Physical Therapy of the American Medical Association.)

Other educational activities include the creation of ten fellowships for training young scientists and surgeons in research on poliomyelitis and related problems, the establishment at Georgia Warm Springs Foundation of a post-graduate school for the training of physical therapists specializing in this work, and the sponsoring of a symposium covering scientific phases of the disease at Vanderbilt University, Nashville, Tennessee. These six lectures, which were given for physicians, have since been published and made available at cost. Exhibits have also been prepared to acquaint the public with the work of the Foundation nationally and locally. During 1939 and 1940, over 5,500,000 people attended the exhibit at the New York World's Fair. A scientific exhibit presented at the American Public Health Association Meeting in Atlantic City in October 1941 was selected as outstanding by the Committee on Scientific Exhibits.

## SOURCE OF SUPPORT

The first Celebration of the President's Birthday was held on January 30, 1934, and the organization of the National Foundation was sponsored by the President on September 23, 1937. These annual Celebrations arose out of the public interest in the work being done on poliomyelitis at the Georgia Warm

Springs Foundation. Upon the establishment of the National Foundation in 1938, growing out of that interest, President Roosevelt transferred to it exclusively the privilege of using his birthday as a means for raising funds for the fight against the disease. The following tabulation shows the allocation of funds raised each year.

STATEMENT OF NET RECEIPTS FROM 1934 TO 1941, INCLUSIVE, SHOWING DISTRIBUTION OF FUNDS FROM CELEBRATIONS OF PRESIDENT ROOSEVELT'S BIRTHDAYS

	Total net amount raised	Left in communities	Given to Georgia Warm Springs Foundation	Given to President's Research Commission	Given to The National Foundation for Infantile Paralysis, Inc.
1934	\$1,016,443.59		\$1,016,443.59		
1935	787,167.30	\$ 544,532.33	1,634.97	\$ 241,000.00	
1936	526,067.30	403,346.04	122,721.26		
1937	1,034,539.58	707,947.19	326,592.39		
1938	1,010,378.14		None		\$1,010,378.14
1939	1,349,483.04	735,195.41	None		614,287.63
1940	1,423,924.87	779,592.16	None		644,332.71
1941	2,148,520.24	1,197,222.22			1,011,298.02
	\$9,296,524.06	\$4,307,835.35	\$1,467,392.21	\$ 241,000.00	\$3,280,296.50
	100.0 percent	46.3 percent	15.8 percent	2.6 percent	35.3 percent

## NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

## PLACEMENTS

- \*Esther M. Finley, Assistant to Director of Nursing Service, Eastern Area, American Red Cross, Washington, D. C.
- \*Irene Thompson, Counselor Reserve, W. K. Kellogg Foundation, Battle Creek, Mich.
- Mrs. Betty McIlce, Industrial Nurse, Mills Novelty Company, Chicago, Ill.
- \*Muriel Fontaine, Staff Nurse, Town Nursing Service, Greenwich, Conn.
- Mrs. Edith L. Robinson, Staff Nurse, Depart-

ment of Public Health, Flint, Mich.

- \*Helen McBride Smith, Staff Nurse, Montgomery County Health Department, Rockville, Md.

## ASSISTED PLACEMENTS

- \*Mrs. Margaret Lynch Kramer, Instructor in Public Health Nursing, Syracuse Memorial Hospital School of Nursing, Syracuse, N. Y.
- \*Eileen C. Dixon, Supervisor of Field Experience in Public Health Nursing Program, Catholic University of America, Washington, D. C.
- \*Margaret Cameron Stafford, Director, The Visiting Nurse Service, Poughkeepsie, N. Y.
- Genevieve Gullingsrud, Staff Nurse, The Visiting Nurse Association, Los Angeles, Calif.
- \*Bernice C. Klumb, Counselor Reserve, W. K. Kellogg Foundation, Battle Creek, Mich.

\*The N.O.P.H.N. files show that this nurse is a 1941 member.

# First Aid Is Too Late

## *Radio Skit and Round-Table*

NARRATOR: The tragic toll of accidents which occur in the home each year can be reduced if not entirely prevented. As a contribution to the prevention of these injuries and deaths, the students of the First Aid and Safety Class of the State Teachers College in Duluth, Minnesota will broadcast a class discussion on the causes of home accidents. But first they will present a short skit. The scene is the home of Mr. Bergan who is just returning from work. He is carefully feeling his way up the icy steps of the front porch when Mrs. Bergan appears at the door to say:

MRS. BERGAN: Hello, John. Oh, by the way, I do wish you would get around to fixing the eaves above those steps. They're so dangerous that I'm afraid to leave the house.

MR. BERGAN: Oh, I don't know when . . . All right, I'll do it now.

NARRATOR: So a few minutes later Mr. Bergan is on top of the ladder chipping ice from the window and pounding on the broken eaves. The fact that the ladder is quite shaky and that the lower ends are resting on slippery ice does not bother Mr. Bergan. He is more interested in getting the job finished. Suddenly without warning, the ladder slips on the glassy ice. Mr. Bergan thrashes his arms wildly in a futile effort to get a hold on the roof top, and a moment later lands with a sickening thud on the steps below. There is a sharp moan of agony as he rolls over and lies very still. Mrs. Bergan comes running from the house.

MRS. BERGAN: John! John! Are you hurt? Answer me. He's coming to. Oh, dear! I must get him into the

house right away. Let me help you up, John. Don't hop on one leg. Can't you use the other one?

MR. BERGAN: O—oh! It hurts!

MRS. BERGAN: Oh, my goodness, he's fainted. What'll I do now?

NURSE: Thank you for presenting this little skit.

HOWARD: Miss Smith, why did you choose that incident in connection with a program on first aid?

NURSE: Because it is an example of what happens every day, over and over again, in many of our American homes. Not only was that accident unnecessary, but I am sure that many of us are appalled by the incorrect first-aid treatment that was given. Originally the fall resulted in a simple fracture, or what is commonly known as a broken leg. If Mr. Bergan had been left where he was until the doctor could get there or until proper splints could have been applied to his leg, he would have been back at work in a short time. But when he tried to stand up, the broken bone cut through the flesh of the leg, causing a compound fracture which takes a great deal longer to heal and is much more dangerous than a simple break.

HOWARD: It seems to me it was the wife's clumsy action that caused the compound fracture. If Mr. Bergan had not been moved, the more severe injury would not have occurred.

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\* This skit was prepared by Catherine E. Vavra and a group of students in the First Aid and Safety Class of State Teachers College, Duluth, Minnesota, and was broadcast by Miss Vavra and students from the class over station WEBC, February 21, 1940. Figures have been brought up to date.

HELEN: Yes, Howard, but if the man hadn't been so careless with the ladder in the first place, the accident would never have happened.

NURSE: You are both right. The compound fracture cannot be blamed entirely on either the wife or husband. In the first place it shouldn't have been necessary to repair the eaves at this time of year, but often such odd jobs are put off until they have to be done hastily under unfavorable conditions. You may find it hard to believe, but fatal accidents in the home are  $1\frac{1}{2}$  times as frequent among men as among women.<sup>1</sup>

ALYCE: Really! How can that be explained when men spend most of the day at work and have so little time at home?

BILL: For one thing, Alyce, they are apt to do the more hazardous jobs such as putting up storm windows and repairing roofs and eaves.

NURSE: That's true, Bill. Besides, many men are inexperienced in these activities and often a man is overly confident of his ability to tackle a job for which he doesn't have the proper equipment. This makes the task more difficult and may place him in an awkward position where he is more apt to have a fall.

HOWARD: That's true, but what about women tackling jobs that *they* are not prepared to do, such as repairing electric wiring, or hanging pictures and curtains while standing on an old chair, or moving furniture alone?

ALYCE: It isn't so dangerous to hang pictures or curtains if you use a steady ladder. Those little kitchen stools that open up into ladders are very steady.

HELEN: The greatest problem in preventing home accidents is to eliminate home conditions and habits that cause falls. Did you know that about half of all deaths from home accidents are due to falls?<sup>2</sup> And a surprising number occur in the bedroom.

HOWARD: What is the reason for that?

NURSE: For one thing it may be due to the use of washable rugs that do not stay put very well on waxed floors. When wax is used on floors, it should be rubbed in so that there is no surplus. Another precaution is the use of non-skid material on the under side of the rugs.

ALYCE: I have seen rubber rings from jars used for this purpose. They were just sewed on the under part near the edge.

HELEN: You can also buy non-skid paste and mats at furniture stores.

NURSE: While we are on the subject of rugs let's remember that it is unwise to place rugs—especially small ones—at the head or foot of the stairs, or on landings. If any rugs are used they should have non-skid material or mats under them to hold them to the floor and prevent their slipping. Carpets on stairs certainly should be held in place by strips securely nailed down to prevent slipping or rolling. A tear or rip in the carpet material should be mended at once, because catching the heel or toe of a shoe in a torn place has been one of the most common causes of accidents reported.

BILL: It seems to me that stairways offer an additional hazard because they are used as storage places for everything from brooms to toys. Often too, they are poorly lighted, and many times people are slow to replace burned out bulbs in stairways. I read in a publication of the National Safety Council that falls on stairs or steps cause at least a sixth of the accidents in the home.<sup>3</sup>

NURSE: Your point about electric bulbs brings to my mind the many accidents which occur because of faulty electric appliances or the mishandling of those that are not faulty. Insurance company figures show that many deaths due to electricity in the home involve the dangerous combination of moisture



with electricity. Hence the danger points are the laundry, the kitchen, and the bathroom. Perhaps some of your friends or families have been involved in such accidents.

ALYCE: I read about a man who came home with a pain in his shoulder and decided that an electric vibrator along with a good hot bath would help him. He got into the tub and applied the vibrator, and because of defective wiring he was electrocuted instantly.

NURSE: Yes, there are innumerable accidents similar to that, and remember that moisture stimulates the flow of electric current, making even non-conductors susceptible to the charge. A dry board is an excellent insulator but it becomes a good conductor if it is wet.

HOWARD: Miss Smith, here is one precaution that should be taken in the home. That is to remove the brass sockets from the kitchen, laundry, and bathroom, and to substitute porcelain ones. They are much safer.

HELEN: I can think of nothing more important than to avoid touching an electrical appliance with wet hands or while standing on a damp floor.

NURSE: Yes, and another important rule is never to handle two electrical appliances at the same time. In case there is a defect in the insulation, you become part of a complete electrical circuit.

BILL: It seems to me the most frequent violator of this rule is the woman who tries to answer the telephone while operating the vacuum cleaner, or the radio, or some other appliance.

ALYCE: Bill, I know of a woman who did that very thing. She held the vacuum cleaner with one hand and took the receiver off with the other. She suffered a shock that was nearly fatal.

NURSE: Isn't it logical that extension cords and those on appliances, especially, are apt to give trouble because of the abuse they receive? Far too

often cords are placed under carpets or in door jambs where the insulation wears off too quickly. Cords which are to be used in the home should be encased in durable rubber tubing or heavy webbing of good quality to guard against the risks of broken wires or punctured insulation.

HELEN: A neighbor of ours bought a cord with only a fabric covering, and one day her baby, who was crawling on the floor, started chewing on the cord. When the saliva soaked through to the unprotected wires, the baby got such a shock that he had to be taken to the hospital.

ALYCE: Yes, and children are often the cause of accidents to others as well as to themselves because they leave their toys lying around on the floor. Last week, a friend of mine slipped on a little train and broke her wrist.

HOWARD: But, Alyce, mothers are often the cause of accidents to their *children* too. Here's a terrible thing that happened in our neighborhood. Little Johnny Brown was watching his mother use a new washing machine and while she was out of the laundry getting more soap, Johnny pulled the lever and started the wringer. He got his hands caught in the wringer and his arms were badly crushed.

NURSE: That's a tragic accident which happens to children all too often, and one that can be prevented by just a little forethought. We could go on indefinitely recalling similar experiences caused by carelessness. Often containers of boiling water are left in dangerous places. For example, kettles are turned with handles protruding over the edge of a stove, or boilers of water are left on the laundry floor. Over a third<sup>4</sup> of the deaths due to burns are in children under fifteen years of age.

BILL: I would say that gas is also a danger in the home. Since carbon monoxide gas has no odor, a person



may be overcome by it without realizing what is happening to him. The early symptoms are definite however. Usually the victim has a headache, a heavy, drowsy feeling, and perhaps a feeling of nausea which he often pays no attention to. These symptoms should be recognized as danger signals. The correct thing to do is to get out of the room and breathe fresh air for a few minutes.

**HOWARD:** Yes, many automobile accidents have occurred as a result of gas leaking through the floor boards of the car, causing the driver to become dazed.

**HELEN:** How can drivers avoid this danger, Howard?

**HOWARD:** The best thing to do is to have cars checked carefully for leaking exhaust pipes. On long trips, in the winter especially when the car windows are usually kept closed, it is a good idea for everyone to get out and walk around the car once in a while.

**NURSE:** Much more could be said about automobile accidents, but we have purposely spent our time on the home problem because the number of accidents occurring in the home is over

three times that of accidents occurring on the highway.<sup>5</sup> Yet 1500 more deaths occurred in 1940 from automobile accidents than from home accidents because of the severity of car accidents.<sup>6</sup>

We would like to ask you who are listening to this broadcast to check your home this evening for some of the more common hazards. Do not put it off. Inspect electrical wiring to make sure it is safe and not overloaded. Be sure to plan to replace worn cords and equipment. Check steps, floors, carpets, porch railings, and other places for hazards, and make minor repairs. Build or buy a good, strong stepladder for the home. Pick up rubbish, tools, and toys, and store them properly. Mark all bathroom boxes and bottles which contain poison.

Here are a few other improvements you might make in the near future: See that your medicine cabinet has provision for the locking of poisons. Rebuild stairs that are not safe. Install handrails on basement stairs. Paint the bottom step in the basement a light color so it is easily distin-

Safety in the home, the  
first important line in  
our national defense



guished. Install hand grips for prevention of falls in the bathtub. Buy or make rubber pads for small rugs to prevent their slipping on floors. The precautions you take to make your home safe will relieve your mind of worry about what might happen. Make your home safe now, for tomorrow may be too late.

## BIBLIOGRAPHY

<sup>1</sup> Metropolitan Life Insurance Company. Statistical Bulletin. May 1938.

<sup>2</sup> Accident Facts, 1941 edition. National Safety Council, Inc., 20 N. Wacker Drive, Chicago, p. 56.

<sup>3</sup> *Ibid.*, p. 106.

<sup>4</sup> *Ibid.*, p. 106.

<sup>5</sup> *Ibid.*, p. 3.

<sup>6</sup> *Ibid.*

## Women and Petrol

AMERICAN NURSES in England are having new experiences with public health work under wartime conditions, according to Dr. John Gordon, director of the American Red Cross-Harvard Field Hospital Unit in England. Dr. Gordon, who is in this country for a few weeks, spoke on December 11 to the nurses of the Henry Street Visiting Nurse Association, which has given three nurses to the Unit for its field work corps.

The American dependence on public health nurses as the backbone of public health work is not so characteristic of British public health practice, said Dr. Gordon. This project offers the opportunity to introduce the possibilities of the American plan of public health nursing to English authorities.

The Unit went to England with two aims: (1) to give aid to a hard pressed people (2) to secure information that would be of aid in our own defense program. It represents a coöperative effort between the American Red Cross, Harvard University, and the British Ministry of Health.

The first members sailed for England in July 1940, and now its hospital—all materials and equipment for which were shipped from this country—is approaching full capacity. The project, which is set up for the "field study" of communicable disease in the locality where these

conditions develop, consists of field and laboratory units and facilities for the clinical care of patients.

The whole problem of communicable disease is intensified under wartime conditions because of factors such as the added stress and strain of life, the new aggregations of people, and the conditions in new industrial projects with concomitant problems of housing and sanitation. In addition, there is an increased strain on organized health authorities. Their number and strength in any community are decreased and their program drastically changed to meet new needs.

The Unit acts as a free lance, "trouble shooting" organization with no definite responsibility for any particular activity or area, able to go where and when a need exists and to act as an aid to overworked health departments. It is set up with its small hospital, laboratory, and field service, to correlate clinical illness with the community situation—the infected city or village with the hospital. The hospital takes patients from the families where public health nurses are working and patients with unusual infections.

Meanwhile, the field nurse, perched on a bicycle with her bag on the handle bars, makes home visits—traveling sometimes 25 to 30 miles a day—to search

(Continued on page 50)

# Your Part in Civilian Defense

By MARIAN G. RANDALL, R.N.

**Y**OU CAN SERVE your country best by doing what you are best prepared to do—nursing.\* In order to preserve our national life in its normal state as nearly as we can, every citizen should carry on his regular job, so far as possible. In addition, those who are able will be needed to do something more. Here are suggestions for the "something more" which you, a nurse, can do:

1. Discover what is being done for defense in your community by consulting your health officer, Chamber of Commerce, local Red Cross chapter, superintendent of schools, or your local defense council.

2. Find out the location of your local defense council, the name of its director, the name of the local chief of emergency medical service, and the names of the advisory board, including the nursing representative.

3. Get in touch with the nursing representative on the local defense council and ask what you can do. If no nursing representative has been appointed, consult the local chief of emergency medical service.

4. Find out whether a nursing defense council has been established in your community. If so, ask how you can participate. There is important work to be done by your nursing council. It should evaluate nursing services in the light of wartime conditions; analyze its local needs and make plans for meeting them; enlist the services of every able-

bodied nurse for some phase of defense nursing; conduct a vigorous public information program; recruit more student nurses; assist the Red Cross and the Office of Civilian Defense in training volunteer nurse's aides; obtain the active support of civic leaders, organizations, and local government officials in the nursing program in defense.

5. If a local nursing council has not been established, get in touch with the secretary of your district nurses' association for assistance in establishing one. If she cannot be reached, write to the secretary of your state nurses' association. Her address is published in every issue of *The American Journal of Nursing*, Official Directory, back advertising pages. The names of paid executives of state nurses' associations appear in the Directory in this issue, pages 61-67.

6. Find out whether your local hospital has organized emergency field medical units. Volunteer to serve in one of these units if needed. The Office of Civilian Defense recommends that every hospital organize emergency units to be ready to give first-aid treatment at the scene of a local incident or disaster when called.

7. Encourage suitable women in your community to volunteer at the local Red Cross chapter for training in the Volunteer Nurse's Aide Corps. Hospitals need many nurse's aides *immediately*.

8. Take a Red Cross first-aid course, if you have not had one within three years. Apply to your local Red Cross chapter for instruction. If no instructor is available, any physician can be certified as an instructor on application to your local Red Cross chapter. Many hospitals and nursing schools have quali-

\* If you can qualify for the Army or Navy Nurse Corps, and can be spared from your present job, ask your local Committee on Red Cross Nursing Service how to apply, or your Area Director of Red Cross Nursing Service.

fied first-aid instructors on their staffs. Ask about them.

9. According to present regulations, nurses qualify as first-aid instructors by taking the advanced and instructor's Red Cross course following the preliminary course. Ask your local Red Cross. If there is no local Red Cross write to your Area Director of Red Cross Nursing Service. Her name and address are listed on page 61 of this issue. The Office of Civilian Defense recommends that one person in every home and one out of every five workers in industry should take a first-aid course unless he has had one recently.

10. Ask your local Red Cross whether teachers in home nursing are needed in your community. If so, apply to the local Red Cross chapter for authorization to teach these courses. See what you can do to organize them in your community. If there is no local Red Cross, write to your Area Director of Red Cross Nursing Service. See page 61 of this issue.

11. Assume responsibility for recruiting at least one well qualified young woman to enter an accredited school of nursing. Qualifications include at least graduation from high school, good health, and pleasing personality. Prepare yourself for this recruiting job by getting copies of *Nursing and How To Prepare for It*, and *Nursing a Profession for the College Graduate*, from the Nursing Information Bureau, 1790 Broadway, New York, New York. Single copies are free. The secretary of your state board of nurse examiners can advise on accredited nursing schools in your area. Her address is given in the Official Directory in every issue of

*The American Journal of Nursing*.

12. If you are ineligible for Army or Navy nursing service, ask about enrollment for some other kind of Red Cross nursing service.

13. If you are not now in active nursing and have the time, prepare yourself to give part- or full-time volunteer or paid nursing service. Ask at your local hospital, health department, or visiting nurse service about a refresher course or special experience. If you cannot take a special course, ask locally what you *can* do.

14. If you are connected with a hospital or public health nursing organization, assure yourself that the jobs which can be done by volunteers have been listed with the local volunteer bureau and the qualifications of volunteers for these jobs stated.

15. Inform yourself what you should tell your patients about what to do in case of emergency. In the hospital you will get this information from the superintendent of nurses or her assistants. In the public health nursing agency, you will get it from the director of the nursing service or your supervisor. Your patients have confidence in you. They respect the instructions and advice which you give them. In general, people should be told that it is safer to scatter than to collect in crowds; that if they are at home, they should stay at home; that if they are not at home, they should seek safe shelter at once.

Every able-bodied nurse can contribute most through her professional service. Every able-bodied nurse can do "something more" in her spare time. Above all else, be cheerful, allay apprehension, inspire confidence.

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The important criterion in judging a professional person's capacities is not the individual mistakes he may make but rather his general ability, his record, and his capacity to learn from his experiences.

—From *The Family*, December 1940, page 271.

# Recommended Qualifications

## *For Public Health Nursing Personnel\**

1940-1945

SINCE the publication of "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing" in 1936,\*\* far-reaching developments have taken place that need to be considered in setting new goals for the next five years. The years 1935-1940 have seen the greatest expansion of public health nursing in its history, due in large part to the health provisions of the Social Security Act. Despite the pressing need for nurses to fill available public health nursing positions, there has been an increasing appreciation by administrators of the importance of appointing nurses specifically prepared for the public health nursing field. The Social Security Act has assisted in this trend by making provision for many nurses to get the needed preparation as well as requiring through a later amendment that appointments be made under a merit system of personnel administration.

The completion of the revised *Curriculum Guide for Schools of Nursing* by the National League of Nursing Education in 1937 has given impetus to the enrichment of the undergraduate curriculum so that the nurse may be more adequately prepared to make her contribution to the health and social welfare of the community in whatever field

she enters. However, since this requires a faculty prepared to assist in the integration of the health and social aspects of nursing throughout the curriculum, increasingly emphasis has been placed on the importance of faculty preparation in these areas by many schools. Also, it is apparent that the graduates from the schools which offer such an enriched curriculum, with a wide range of clinical experience including communicable and mental diseases, will be considered potentially the most promising for public health nursing service. The membership list of the Association of Collegiate Schools of Nursing and the National League of Nursing Education's list of accredited schools will be helpful in furnishing another basis for the selection of graduate nurses for public health nursing.

The growth of merit systems as a method of selecting personnel both in official and nonofficial agencies has made for greater understanding by agencies and by citizens of the need for specific requirements for the various positions in the field of public health nursing. The qualifications recommended here have been formulated in the light of these present trends in qualifications for public health nurses wherever they may be employed.

Determined effort to reduce further certain existing health problems, such as crippling in children, maternal and neonatal hazards, tuberculosis, and the venereal diseases, has made emphasis on special services in these areas necessary. Each of these is recognized as one part of the whole family health service, and

\* Approved by the Education Committee of the National Organization for Public Health Nursing.

Reprints will be available free of charge from the Organization, 1790 Broadway, New York, N. Y.

\*\*Published in PUBLIC HEALTH NURSING, March 1936, page 172.

as such, is most adequately carried on by the field nurse who is responsible for all phases of the public health nursing program. The nurse, however, needs help from consultants who in addition to the necessary equipment as supervisors have had preparation in the special field in which they are engaged.

Mindful of these trends and realizing that the first principle underlying the improvement of service is the appointment of qualified personnel, the Education Committee of the N.O.P.H.N. recommends these qualifications for those appointed to public health nursing positions as the goal for 1945. They are based on the principles: (1) that one of the most essential requisites in public health nursing is the ability to work effectively with people (2) that the public health nurse must be a competent nurse with sound basic theoretical and clinical preparation in nursing and with an understanding of its social and health aspects (3) that additional study, including supervised field experience, is essential to prepare the graduate nurse for the specific functions of public health nursing (4) that continued in-service education including qualified supervision (see II, A of outline) is necessary to further the development of the nurse's potentialities for improved service to the individual family and community, which is the goal of all public health nursing.

#### PERSONAL FACTORS IMPORTANT

While the following qualifications may seem to stress academic preparation and professional experience, personality remains a major factor in successful public health nursing service, and therefore must always be given due consideration. Also, good physical health as determined by a preemployment examination should be considered essential because without it the other qualifications are rendered less effective.

Improvement in the technique of per-

sonal interviews and the collection of credentials, through study of personnel methods in other fields, will help in developing more accurate methods for the selection of applicants with fundamental requisites. Tests and other measurements need to be studied as a means of determining individual abilities and capacities.

On the other hand, it is important for both the nurse and the employer to understand the purpose and value of theoretical preparation for public health nursing. University study should be an economical means to the end of greater competency in daily work and not an end in itself. It is a means for the nurse to review under guidance past and present practice in this field in order to become familiar with sound, workable principles and thereby avoid some of the trial-and-error learning common to all new workers. It is an opportunity to gain additional tools, both in content and method, which will make work in the field more pertinent and more productive.

Unusual competence in the work to which the nurse is assigned is the only sound basis for promotion to greater responsibility and the one most frequently used. Well utilized graduate study should assist in the development of such competence. The amount of study suggested in these recommended qualifications is believed to represent the minimum needed for each type of worker described.

While these qualifications apply specifically to new appointees, the importance of corresponding additional preparation for those already appointed should receive careful consideration in relation to each nurse. Under certain conditions, it might be desirable for agencies to adopt a policy urging those appointed within the last few years to meet within a specified period of time the recommended theoretical preparation for the respective positions.



### I. STAFF NURSES\*

A. For the nurse working on the staff of an official or private agency under the direct supervision of a nurse supervisor who meets the qualifications herein set forth.

Duties: To carry on the direct nursing service of the agency in the home, clinic, conference, school, or industry.

#### Preparation:

1. General education—High school graduation or its educational equivalent which meets college entrance requirements. Education on a college level is desirable.

2. Basic nursing education—Graduation from an accredited\*\* school of nursing connected with a hospital having a daily average of 100 patients, with the necessary affiliation, which gives the nurse a broad clinical experience in medical nursing, including acute communicable disease, tuberculosis, and the venereal diseases; psychiatric and pediatric nursing (including the care of children with orthopedic and cardiac conditions); and an understanding of the social and health aspects of nursing, both physical and mental, through an integrated program of instruction in classroom, ward, outpatient department, with appropriate use of community facilities.

3. State registration.

4. Postgraduate study—Completion of the year's program of study in public health nursing in a university program approved by the National Organization for Public Health Nursing, previous to or within five years after appointment.

B. For the nurse in an official or private agency not working under direct supervision.

Duties: In addition to carrying on the direct nursing service of the agency as in A, to assist in organizing the service; to work with lay and professional groups; to carry on the activities in spe-

cial situations such as the school and industry.

#### Preparation:

1. General education—Same as listed for staff nurse under A.

2. Basic nursing education—Same as listed for staff nurse under A.

3. State registration.

4. Postgraduate study—Completion of the year's program of study in public health nursing in a university program approved by N.O.P.H.N., before appointment.

5. Experience—At least one year's experience under qualified nursing supervision in a public health nursing agency in which family health is emphasized.

### II. SUPERVISORS AND EXECUTIVES

#### A. For the supervisor.

Duties: To supervise the staff nurses in an official or private agency and to assist in their growth and development; to plan and develop the nursing program for which she is responsible in relation to the total program of the agency; to correlate it with that of other agencies in the educational, social, and health fields; to study and evaluate the program within her own area.

#### Preparation:

1. General education—College degree.

2. Basic nursing education—Same as listed for staff nurse under I. A.

3. State registration.

4. Postgraduate study—Same as listed for staff nurse under I. B., and in addition, a course in principles of supervision.

5. Experience—At least two years' experience, one of which was under direct, qualified nursing supervision in a public health nursing service in which family health is emphasized.

\*See recommended qualifications for public health nurses in school and industry, PUBLIC HEALTH NURSING, February 1938, page 108; July 1939, page 410. Reprints are available free of charge.

\*\*Accredited by the state board of nurse examiners.

**B. For the consultant.**

**Duties:** To assist in analyzing the needs and developing the service in the special field; to correlate this service with other services offered by the agency and with the programs of other agencies; to advise regarding policies, techniques, and procedures in the special field; to participate in the supervisory and staff-education program of the agency in cooperation with the other supervisory personnel.

**Preparation:**

1. General education—College degree.
2. Basic nursing education—Same as listed for staff nurse under I. A.
3. State registration.
4. Postgraduate study—Same as listed for staff nurse under I. B., and in addition a course in principles of supervision and advanced preparation in the special field, including content in that field, courses in general education, and methods of making and using studies.
5. Experience—At least two years' experience, one of which was under direct, qualified nursing supervision in a public health nursing service in which family health is emphasized, and at least one year's experience as a generalized supervisor.

**C. For the educational director or instructor in public health nursing.****Duties:**

In public health nursing agencies—to plan and to direct the educational program for the new nurse, for the student, and for the staff as a whole, and to correlate and develop the resources of the agency and of related community services for teaching purposes.

In schools of nursing—to assist in directing, to correlate, and to participate in the efforts to give the undergraduate student the concept of the social and health aspects of nursing, both physical and mental, through an integrated program of instruction in classroom, ward,

and outpatient department, with appropriate use of community facilities.

**Preparation:**

1. General education—College degree.
2. Basic nursing education—Same as listed for staff nurse under I. A.
3. State registration.
4. Postgraduate study—Same as listed for staff nurse under I. B., and in addition, courses in principles of supervision and in the philosophy and principles of education.
5. Experience—At least two years' experience, one of which was under direct, qualified nursing supervision in a public health nursing service in which family health was emphasized and at least one year's experience as a supervisor in a public health nursing service.

**D. For the director.**

**Duties:** To administer the nursing service of the official or private agency; to determine with the administrative official or the board the policies and program to be followed; to interpret the needs of the nursing service to the administrative officials, to the board, to committees, and to the community; to participate in community planning and action in health and social welfare.

**Preparation:**

1. General education—College degree.
2. Basic nursing education—Same as listed for staff nurse under I. A.
3. State registration.
4. Postgraduate study—Same as listed for staff nurse under I. B., and in addition, courses in supervision and in principles of administration.
5. Experience—At least three years' experience, preferably in more than one type of agency—*i.e.*, official and private—including experience in supervision.

**E. For the director of a university program of study.**

**Duties:** To assume direct responsi-

bility for the planning and administration of the program.

Preparation:

1. General education—Graduate degree.
2. Basic nursing education—Same as listed for staff nurse under I. A.
3. State registration.
4. Postgraduate study—Completion of the year's postgraduate program of study in public health nursing in one of the university programs approved by the N.O.P.H.N., before appointment, and

advanced university courses in general education and in supervision and administration in public health nursing.

5. Experience—A minimum of five years of public health nursing experience, preferably in more than one agency, one year of which should have been in a general public health nursing agency with direct, qualified supervision, emphasizing family health. This experience should include experience as a staff nurse and experience as a supervisor, executive, or educational director.

## News from the S.O.P.H.N.'s

**W** E PUBLIC HEALTH NURSES, the monthly bulletin of the Arkansas S.O.P.H.N., made its first appearance in September 1941. It's a newsy letter of three pages, mimeographed on regular letter-sized white paper, which is sent monthly to every public health nurse in the state regardless of whether she is a member of the Organization.

At the present time we do not have a completely functioning committee for this job. The chairman of the Committee on Publications and the editor put the material together and prepare it in final form. The material is gathered by the nurses on the advisory staff of the State Board of Health, who get around the state regularly, keeping their ears to the ground for interesting news items. Telephone calls are made to the local agencies in Little Rock for information from their organizations. Items also come in from a few individual nurses.

When all the news items are received, the chairman of the committee writes them up in narrative form and sends them to the other committee member. She in turn rewrites them in better news form, arranges the format of the bulletin, and does the final editing. She also makes the stencil for the bulletin and

sends it to the chairman, who does the mimeographing, folding and addressing. The bulletin is folded into three parts which are held together by a sticker. The address is then typed on one side and a one and one-half cent stamp affixed for mailing.

The stencils and paper are furnished by the State Board of Health, and the mimeographing is done at its offices. Postage is paid by the State Organization for Public Health Nursing.

MARGARET S. VAUGHAN, R.N.  
*President, Arkansas S.O.P.H.N.*

**T** HE ANNUAL meeting of the Council of Branches will be held on January 22 in the Hotel Roosevelt in New York City, just preceding the annual N.O.P.H.N. Board of Directors meeting. In view of the serious situation facing the country today, this meeting of representatives from the various state organizations for public health nursing is especially important and it is hoped that every state can send a representative. Plans for nursing in national defense and the organization of defense programs for local communities will be discussed.

## How Long Should Records Be Kept?

NINE LARGE nonofficial public health nursing agencies were recently asked by the National Organization for Public Health Nursing to explain their policies about the filing and keeping of family folders and individual records. The inquiry was made because the Organization has had many requests for advice as to how long records should be kept, and no recent review had been made.

All nine of the large agencies that were asked for their policies about records used family folders, but only two reported that a family folder was made out for every patient regardless of amount of service, and one of these stated that the family folder was not completely filled in for families in which there seemed to be no problem. The instances in which family folders were not made out included one- and two-visit cases, hourly-appointment cases, and patients without families.

### WHEN ARE RECORDS DESTROYED?

Replies about destroying family folders seem to show that keeping family folders for at least five years is satisfactory. Six of the nine large agencies said that family folders were destroyed if there had been no contact with the family for a period of five years. One agency said that they destroyed family folders which had been inactive for four years. One said that their policy was to destroy all inactive records in two years, unless there were significant social or medical data recorded. On the other hand, one agency said they were increasingly reluctant to part with any records—family folders, child health, maternity, and tuberculosis records, or the face sheet of morbidity records—and that they were not destroying any so long as the filing space permitted.

Variations in policies were even wider regarding individual case records. Three of the agencies destroyed individual records at the end of five years of inactivity of all members of the family, *i. e.*, when the family folder was destroyed. Two agencies said that two years was the period after which they destroyed individual records; one limited this by saying that morbidity and maternity records were not kept more than two years. One agency said that individual records were kept four years. One agency has found it satisfactory to destroy individual records after the record has been statistically analyzed as a closed case, even though no family folder had been opened for it; however, at rare intervals a supervisor does make a brief summary of such a case and put it in a dummy folder. One agency had an arrangement with the health department nursing service whereby the infant records were summarized on the agency's family folder and the individual infant's record itself is sent to the health department to be continued during the preschool period by the official agency. This same agency stated that if the family folders became very bulky the individual records were summarized and were then destroyed—particularly the morbidity records. The agency which believed it wise to keep all records stated that the last records they had destroyed were the continuation sheets of morbidity cases discharged in the years 1934 and 1935.

From these replies it is evident that there is no universal practice about the length of time for keeping records. Some states have regulations as to the length of time records such as those of public health nursing agencies can be called upon, and such regulations will affect the decisions about destroying records. With-

out a doubt the accuracy and completeness of the contents of the records and the uses made of them influence the desirability of keeping them for help in future service. Also the space available for storing inactive records may make a difference. Possibly replies from a larger number of agencies would be useful to

show further policies about family folders and individual records. If this short resumé is quite outside the policies in your organization, will you let the N.O.P.H.N. know your policies also?

DOROTHY E. WIESNER

*Statistician, National Organization  
for Public Health Nursing*

## "Happiness for Children Now"

**L**IFE, Liberty, and Happiness for Children Now" was the theme of the Ninth Biennial Conference of the National Association for Nursery Education in Detroit, October 24-27. As Dr. Bess Goodykoontz of the U. S. Office of Education pointed out, these are provisions of our constitution for all our people. Today, more than ever, we are conscious of the needs of children in these areas. The time of the conference members was devoted to consideration of ways of achieving these goals.

Workers in various fields met together in seminar and service group meetings to explore such subjects as: nursery education as a force in the continuous growth process, providing for healthful living, community planning for the well-being of young children, implications of recent findings in nutrition research, today's problems in food and feeding, providing for the spiritual growth of the preschool child, family life education in housing projects, and working with parents in nursery education.

All phases of child life were considered, but especially significant was the fact that no matter what phase of child life was announced as the subject, soon "the whole child" was brought into each discussion. In the sessions on nutrition research and on problems in feeding, which met jointly at least once, it was pointed out that in order to judge a

child's nutritional status one must know about his behavior, his general personality, the findings of his medical examinations, his posture, body build, appetite, color, subcutaneous fat, sleep habits, number of colds, and other factors. No longer are height and weight considered sufficient indices.

The necessity for a varied diet in order to include all the essential food elements was stressed. Milk maintained its position as an essential food in the diet. The importance of the thiamin factor of vitamin B was emphasized because of the high carbohydrate content of the American diet and because of the function of thiamin in the utilization of carbohydrates. Enriched bread is a good source of thiamin. The fact that various mineral elements and protein foods—as well as iron—affect the hemoglobin count was also noted.

The recommended daily allowances for specific nutrients set up by the Committee on Foods and Nutrition of the National Research Council are our best guides until changes are made based on further research. Hence all public health nurses need to keep up to date on current literature in this field. In an effort to obtain answers to questions facing workers who are feeding children, some participants tried to press the research workers for new findings which are not yet released. However, the research workers refused to make



premature statements that may not be substantiated by future research. But the discussion gave them some understanding of the problems facing the workers in the field. It was interesting to realize that these two groups—research workers and those feeding children—who are headed toward the same goals though traveling different routes, could discuss their problems together.

The role of the public health nurse in relation to the nursery school and other phases of preschool education was considered in the section on "Providing for Healthful Living." The need for periodic examinations of teachers and other workers with young children was stressed. Some members of this group believed the nursery school teachers should assume responsibility for working with nursery school parents to establish desirable attitudes toward health measures such as immunization and periodic examinations. But for many a preschool child it will be the public health nurse who as the educator of the entire family will render this service. Throughout this discussion the child in all of his relationships and functionings was considered. "Providing for healthful living" is not a limited phrase referring to physical health alone.

Knowing that such a broad approach to child development must include parents and parent education, the section on "Working With Parents" discussed all community efforts in parent education. Noteworthy was the stated realization that parents have needs which were met inadequately in their own childhood. A function of those en-

gaged in parent education is to meet individuals and groups of parents wherever their needs are and to minister to them in ways which will be acceptable and usable to them. Workers with parents need to be mature people, to understand themselves. Growth on the part of such workers is as possible and desirable as the growth which we are eager to stimulate in parents.

Growth of professional workers as well as of parents comes through insight and development of broadened and deepened attitudes, which in turn are generated through our own thinking and doing. Group functioning in the gaining of information was given real importance. Drawing from experience and sharing experiences in the pursuit of general principles are functions which parents can exercise, contributing practical knowledge, and acquiring a sense of their own worth and ability in so doing. Professional workers need to aid parents to gain such feelings toward themselves, especially in relation to the workers.

One was gratefully aware of the true cooperation between various agencies concerned with early childhood development. Community integration seems to be a reality. The conference ended emphasizing the point that professional workers must watch with interest and join as fully as possible in the defense efforts concerning children in order that the quality of leadership may be high.

KATHRYN HACKER,  
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Detroit, Michigan*



# Our Nursing Resources

A progress report of the national inventory of registered nurses to determine our nursing resources\*

**A**MERICA NEEDS nurses now to help meet the present emergency and will need many additional nurses as the emergency becomes more acute. One of the first steps in preparing to meet any emergency is to know your resources. The Nursing Council on National Defense recognized the necessity for that step more than a year ago when it made plans for a national inventory of all registered nurses with the help of the state nurses' associations and requested the United States Public Health Service to aid in the conduct of the survey.

As a preliminary step, a survey schedule or questionnaire was prepared early in October 1940 and during the month of November it was tried out in the District of Columbia to see whether the items were easily interpreted by the nurses and whether the information obtained would meet the needs of defense agencies. With a few minor changes the schedules were printed as originally planned, and supplies were made available to begin the nationwide survey shortly after January 1, 1941.

## APPOINTMENT OF SPECIAL AGENTS

Through the efforts of the Nursing Council on National Defense, every state nurses' association designated a person who would be responsible for the survey within that state. The person selected most frequently was the executive secretary of the state nurses' association. In some instances it was the

secretary of the state board of nurse examiners. These state representatives were given federal civil service appointments as "special agents" of the United States Public Health Service and were empowered to send letters in government "penalty" envelopes and to use Public Health Service stationery.

In order to have some uniformity in the conduct of the inventory, each state nurses' association was asked to send its representative to Washington for a preliminary conference and on January 10, 1941, representatives from 39 states and the national agencies assembled in Washington and helped prepare the plans and procedures for the conduct of the inventory.

At this conference it was agreed that:

1. Schedules (or questionnaires) should be filled out by *every* graduate nurse who was or had been registered in any state at any time, whether she was employed or not employed in active nursing work when she received the schedule.

2. The schedules would be accredited to the state in which the nurse lived and/or worked. Schedules received from nurses who were now living in other states were to be forwarded to the special agent of the state in which the nurse lived.

3. In editing the schedules, no original entries on the individual schedules were to be obliterated. Additional information was to be put on in black lead pencil. The most important items to be edited by the state representatives were those which pertained to the registration of the nurse.

4. All completed schedules were to be shipped to the Public Health Service for tabulation by May 1, 1941. (The date was later changed to July 1.)

5. Each state nurses' association was to determine how much information from the schedules would be taken off for local use. A sample 5 x 8 inch card with certain pertinent information was suggested as the most feasible for the majority of the states.

## WORK WITHIN THE STATES

The cooperation of the state nurses'

\*Prepared by Pearl McIver, Senior Public Health Nursing Consultant, U. S. Public Health Service, Washington, D.C.

associations, alumnae associations, and nursing service administrators was excellent. Almost 460,000 schedules were distributed, and approximately 75 percent were returned to the state agencies by July 1—a remarkably fine return from a questionnaire type of survey. About 7½ percent of those returned were duplicates, were addressed to nurses not now living, or were addressed to nurses whose present address was unknown. Thus, the number of schedules available for tabulation represents about two thirds of the number originally distributed.

The "special agents" have reported almost unanimously that the inventory has already been extremely valuable to them from a local and state angle. However, its value on a state basis depends upon the usability of the data which were taken off the schedules. Already several states have furnished the State Committees on Red Cross Nursing Service with lists of nurses who are eligible for enrollment in the First Reserve of the American Red Cross. Names of inactive nurses who are available for active duty have been submitted to schools of nursing offering refresher courses. Lists of inactive public health nurses have been furnished to some state health departments so that those who are eligible may be offered positions in order to replace nurses who have accepted public health positions in defense areas.

#### COST OF THE INVENTORY

A conservative estimate of the cost of the inventory, exclusive of the time spent by the many volunteer nurses and lay workers within the states and the additional clerical help required by the state offices, is about \$65,000. Of that amount, \$10,000 was secured from the Health and Medical Committee\* through its Subcommittee on Nursing. The

American Red Cross donated \$5,000; the United States Public Health Service contributed about \$5,000 in supplies and service; and about \$45,000 worth of clerical services was secured from the Work Projects Administration.

Almost 300,000 completed schedules were returned to the Public Health Service for tabulation. The funds available paid for the schedule forms, the coding, and the placing of the material on punch cards, and will be sufficient to carry through the major part of the tabulating until July 1, 1942. Thus the cost per schedule (exclusive of volunteer assistance) is a little more than twenty cents.

By November 15, 1941, all of the schedules had been coded and placed on punch cards, and tabulations had been made on the data from a sample composed of nine selected states. The Work Projects Administration project in Philadelphia was then closed and all of the material was transferred to the Public Health Service in Washington, where the tabulations will be made from now on.

#### FORMATION OF ADVISORY COMMITTEE

Since the Subcommittee on Nursing of the Health and Medical Committee was given official responsibility for the inventory, a special committee to advise the Public Health Service with regard to "priority tabulations" and the most effective use of the material was appointed by the Subcommittee on Nursing in October 1941. This committee is under the chairmanship of Marian G. Randall, newly appointed nursing consultant to the Office of Civilian Defense. Included on the committee are:

Mrs. Alma H. Scott, Director of Headquarters, American Nurses' Association

Virginia M. Dunbar, Assistant Director, Nursing Service, American Red Cross

Ruth Houlton, General Director, National Organization for Public Health Nursing

Blanche Pfefferkorn, Director of Studies, National League of Nursing Education

Mrs. Elmira Bears Wickenden, Executive

\*The Health and Medical Committee, Council of National Defense, now Office of Defense Health and Welfare Services.

Secretary, Nursing Council on National Defense

Alma C. Haupt, Nursing Consultant, Health and Medical Committee, Office of Defense Health and Welfare Services

This committee met in Washington on November 28 and reviewed the data secured from the trial tabulations. Some of the recommendations from the committee were:

1. That since the nine selected states represented the several geographic areas of the country and in other respects appeared to be a representative sample of the country as a whole, the percentages from this sample should be applied to the entire inventory data so that we may have immediately an approximate picture of our nursing resources.

2. That similar tabulations be made of all of the material as soon as possible (not later than July 1, 1942) and that copies be made available to the state and national agencies which participated in the survey.

3. That alphabetic lists (lists which include the name with other identifying data) be made only in response to specific national defense needs. As an example, it was voted that the very first lists made would be those of unmarried nurses under 40 years of age who were not enrolled in the American Red Cross. The needs of the Army Nurse Corps are very urgent, and meeting that need is probably the most pressing defense problem in nursing.

If a serious disaster should occur in a local community which required the immediate services of a large number of nurses, it would be possible to furnish

on short notice to the local authorities the names of all nurses within a reasonable radius of that area who would be willing to give volunteer or part-time service.

#### WHAT DOES SAMPLE SHOW?

The nine states represented by this sample include 68,163 schedules or about one fifth of the number received for the whole country. The states selected represent the several geographic regions of the country, rural and urban populations, industrial and nonindustrial areas.

From this sample it appears that about two thirds of the nurses who filled out schedules were employed at the time. About one third were not employed full time when the schedules were made out. About one fifth of the inactive nurses said they were available for full-time duty if needed. If we consider our total as approximately 300,000 (290,120 to be exact), this means that of the nurses who were actively employed, about 200,000 filled out schedules. About 100,000 of those not employed filled out schedules, but of that number only one fifth, or about 20,000, said they were available for full-time duty if their country needed them.

TABLE I  
DISTRIBUTION OF REGISTERED NURSES IN NINE SELECTED STATES ACCORDING TO EMPLOYED OR INACTIVE STATUS, AND IF INACTIVE, AVAILABILITY FOR FULL-TIME NURSING WORK<sup>1</sup>

States	Total		Nurses employed full time		Inactive nurses			
					Available for full-time duty		Not available for full-time duty or unknown as to availability	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	68,163	100.0	44,937	65.9	4,585	6.7	18,641	27.4
Colorado	3,668	100.0	2,402	65.5	315	8.6	951	25.9
Indiana	6,923	100.0	4,265	61.6	480	6.9	2,178	31.5
Louisiana	4,730	100.0	3,308	69.9	412	8.7	1,010	21.4
Maryland	4,504	100.0	2,974	66.0	227	5.0	1,303	29.0
Massachusetts	14,531	100.0	9,704	66.8	717	4.9	4,110	28.3
Minnesota	6,616	100.0	4,490	67.9	425	6.4	1,701	25.7
Ohio	14,534	100.0	9,931	68.3	866	6.0	3,737	25.7
Texas	7,142	100.0	4,732	66.2	626	8.9	1,784	24.9
Washington	5,515	100.0	3,131	56.8	517	9.4	1,867	33.8

<sup>1</sup> Nurses participating in the National Survey of Registered Nurses, 1941.

TABLE II  
THE AGE DISTRIBUTION OF ACTIVE NURSES IN NINE SELECTED STATES,  
BY TYPE OF POSITION<sup>1</sup>

Type of position	Age group											
	Total		30 and under		31-40		41-50		51-60		61 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	44,621	100.0	22,061	49.4	12,363	27.7	6,191	13.9	2,752	6.2	587	1.3
Institutional	21,462	100.0	12,265	57.1	5,259	24.4	2,351	11.0	1,005	4.7	249	1.2
Public health	4,270	100.0	1,156	27.1	1,345	31.5	1,067	25.0	549	12.8	90	2.1
Private duty	15,230	100.0	7,007	46.0	4,615	30.3	2,203	14.5	973	6.4	203	1.3
Other types	3,659	100.0	1,633	44.7	1,144	31.3	570	15.6	225	6.1	45	1.2
											42	1.1

TABLE III  
THE AGE DISTRIBUTION OF INACTIVE NURSES IN NINE SELECTED STATES WHO ARE  
AVAILABLE FOR FULL-TIME WORK, BY TYPE OF POSITION<sup>1</sup>

Type of position	Age group											
	Total		30 and under		31-40		41-50		51-60		61 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	4,377	100.0	1,390	31.8	1,610	36.8	890	20.3	341	7.8	80	1.8
Institutional	1,671	100.0	629	37.6	581	34.8	283	16.9	131	7.8	21	1.3
Public health	376	100.0	68	18.1	123	32.7	128	34.1	40	10.6	14	3.7
Private duty	1,566	100.0	431	27.5	648	41.4	311	19.9	114	7.3	33	2.1
Other types	298	100.0	90	30.2	104	34.9	70	23.5	22	7.4	5	1.7
Type unknown	466	100.0	172	36.9	154	33.1	98	21.0	34	7.3	7	1.5
											1	0.2

<sup>1</sup>Nurses participating in the National Survey of Registered Nurses, 1941.



In the nine selected states, the percentages of inactive nurses who were available varied from 4.9 in Massachusetts to 9.4 in Washington.

The age distribution of the available nurses is important. Almost half of the nurses who were actively employed were under 30 years of age; only 6 percent were over 50 years of age. When the age distribution is broken down into type of work, the picture changes. Then we find that 57 percent of the institutional nurses were under 30 years of age but only 27 percent of the public health nurses were in that age group. Almost half of the private duty group were also under 30 years of age. This is not surprising, as most young nurses do private duty or general duty in hospitals immediately after graduation.

It would appear that marriage and not age is the reason for those in the inactive group becoming inactive. More than two thirds of the inactive—but available—nurses who filled out schedules were under 40 years of age. Thirty percent of them were under 30 years of age, so that it appears there may be at least 6000 young nurses who are now inactive but who would be willing to accept full-time employment if the emergency should become very acute.

The distribution of nurses according to type of position as revealed by the sample data was quite significant. Of the actively employed nurses represented

by the sample tabulations, about 48 percent were engaged in institutional work. (This includes general staff, supervisors, administrators, and teachers in schools of nursing.) About 34 percent were engaged in private duty and over 9 percent were listed as public health nurses. Eight percent were engaged in other types of work. A little less than one percent failed to indicate the type of nursing they were doing when they filled out the schedules.

This picture is different from those previously obtained from the American Nurses' Association membership lists; but is it not likely that the percentage of private duty nurses who are American Nurses' Association members would be greater than the percentage of general duty nurses in hospitals because A.N.A. membership is usually required by the registries and it often is not a requirement for general duty work? Then, too, a few states reported that it was more difficult to secure schedules from the private duty group. Possibly our percentage of returns is lower for that group than for the institutional and public health groups.

Of the inactive nurses who are available for full-time duty, the percentage distribution according to type of work is similar except for the private duty group which is slightly higher. (Does that mean that private duty nurses are more likely to marry young or does it

TABLE IV  
DISTRIBUTION OF ACTIVE AND INACTIVE NURSES IN NINE SELECTED STATES WHO WERE IN CERTAIN TYPES OF NURSING POSITIONS<sup>1</sup>

Type of position	Active		Inactive and available full time	
	Number	Percent	Number	Percent
Total	44,937	100.0	4,585	100.0
Institutional	21,462	47.8	1,885	41.2
Public health	4,270	9.5	425	9.3
Private duty	15,230	33.9	1,726	37.6
Other types	3,659	8.1	341	7.4
Unknown type	316	0.7	208	4.5

<sup>1</sup> Nurses participating in National Survey of Registered Nurses, 1941.

TABLE V  
PERCENTAGE DISTRIBUTION OF ACTIVELY EMPLOYED NURSES IN NINE SELECTED STATES, BY TYPE OF POSITION AND ACADEMIC PREPARATION<sup>1</sup>

Type of position	Total	College		High school		Unknown
		Graduate	Some	Graduate	Less	
Total	100.0	4.5	25.5	57.8	1.0	11.2
Institutional	100.0	5.8	26.7	58.1	.7	8.7
Public health	100.0	12.6	51.1	26.9	.8	8.6
Private duty	100.0	1.0	16.4	65.8	1.6	15.2
Other types	100.0	2.3	25.6	58.4	1.2	12.5

TABLE VI  
PERCENTAGE DISTRIBUTION OF INACTIVE NURSES AVAILABLE FOR FULL-TIME WORK IN NINE SELECTED STATES, BY TYPE OF LAST POSITION AND ACADEMIC PREPARATION<sup>1</sup>

Type of position	Total	College		High school		Unknown
		Graduate	Some	Graduate	Less	
Total	100.0	2.1	25.8	52.9	1.8	17.4
Institutional	100.0	2.6	27.5	52.9	1.4	15.6
Public health	100.0	5.3	47.4	32.9	1.2	13.2
Private duty	100.0	0.9	18.4	58.0	2.4	20.3
Other types	100.0	1.8	27.0	51.9	17.8	1.5

<sup>1</sup> Nurses participating in the National Survey of Registered Nurses, 1941.

mean that more of them are willing to return to active nursing work?)

Academic preparation is not the most significant requirement of a good nurse. However, it was interesting to find that about 5 percent of the actively employed nurses who filled out schedules were college graduates and another 25 percent had completed some college work. Only one percent of the active nurses had not completed high school. If this group were analyzed by age groups, it would undoubtedly be heavily loaded with older nurses. This is a very encouraging showing when one realizes that only 70 years ago an editorial in Godey's Lady's Book asked whether it was too much to expect that some day there might be educated women in the field of nursing!

When academic preparation is analyzed by type of position, it appears that about 13 percent of the public health nurses have college degrees and about 64 percent of them have had some college work. This is not surprising, since

college preparation in the field of public health has been a public health nursing recommendation for many years. About six percent of the institutional group are college graduates. When this group is further broken down into administrators, teachers, general staff, et cetera, the percentage of college graduates among the administrative and teaching group will no doubt be much higher.

The academic preparation of the inactive group available for full-time service is lower in every type of position but maintains somewhat the same relationship as that for the active group. Only 2 percent of this group were college graduates, as compared to 5 percent for the active group.

#### SCHEDULES FROM 1941 GRADUATES

The "special agents" in each state have been asked to secure schedules on all nurses graduated and registered in 1941, who were not included in the inventory last spring. An annual inventory of all new graduates will be re-

quired throughout the emergency. It is hoped that these schedules can be completed and mailed to Washington for tabulation not later than February 1 of each year. Arrangements will be made to have these new schedules coded and tabulated as rapidly as possible so that the records will always include those nurses who are most likely to qualify for the First Reserve of the American Red Cross Nursing Service and be available for military duty.

Every nurse who filled out a schedule in the National Inventory of Regis-

tered Nurses, by so doing indicated her willingness to participate in a program of national defense. The various groups of nurses who sponsored this project are demonstrating their ability to work as a unit to meet nursing needs during this national emergency period.

The purpose of the inventory is to meet the immediate needs of our country for nursing service but the historical value of these data to the nursing profession can scarcely be evaluated at the present time. Nursing history is being made!



## GONORRHEA RESPONDS TO TREATMENT

**A** FOUR TO ONE chance of cure of gonorrhea in men within five weeks after beginning of treatment with sulfathiazole and sulfapyridine was reported today by the United States Public Health Service. Comparison of gonorrhea cases treated with the two drugs indicated sulfathiazole is the more effective. Sulfathiazole works faster in clearing symptoms and is less toxic than sulfapyridine.

The report was based on findings in eight clinics cooperating with the Public Health Service and the American Neisserian Medical Society. The apparent cures were based on disappearance of symptoms and negative bacteriological tests.

At the end of five weeks either drug had cured 82 percent of the patients,

although sulfathiazole cleared the symptoms of 61 percent in the first week as compared with 44 percent for sulfapyridine. Toxic reactions of such severity that treatment had to be stopped occurred in 3.8 percent of sulfapyridine and 1.3 percent of sulfathiazole cases.

Public health investigations in defense areas show that gonorrhea is found more often than any other venereal infection. Public Health Service officials believe, however, that treatment of gonorrhea by drugs is so effective that the disease could be eliminated as a public health problem within several years if an adequate nation-wide program were developed.

—From release from United States Public Health Service, Washington, D.C., May 19, 1941.

# A Program for Staff Education

## *Industrial Nursing*

**I**NDUSTRIAL WORKERS constitute a large section of the nation's population and are an integral part of the communities in which they live and work. Industrial health or the lack of it, therefore, has a significant effect not only on industrial output but also on the health of the community as a whole. Manufacturers, employees, industrial hygienists, and members of the medical and nursing professions increasingly realize this and agree that definite steps should be taken to meet existing health problems in industry.

One of the most immediate problems to be faced in any program to reduce absenteeism of workers is that of providing health service in industry. The problem is not an easily solvable one, particularly in small industries employing 500 workers or less. However, experience in several industrial communities has shown that it is both possible and practicable to provide nursing service through the utilization of the service of local public health nursing associations. This plan is especially applicable in industrial plants which are too small either to require full-time services or to be able to afford them.

If public health nurses are to provide the best possible service to industry, they need to understand both community and industrial health problems. They must know how these problems affect industrial workers and their families, both in the home and in the workplace. They need to be familiar with the available methods and resources for preventing illness and promoting health.

A number of public health nursing agencies already have staff nurses with the necessary training and background

for providing service to industry. Many other nursing organizations are desirous of providing services, but their staff members do not have the necessary preparation. It is for these agencies that the National Organization for Public Health Nursing has prepared the following outline for a staff education program in industrial nursing. The outline, which is offered as a general approach to the subject, is intended to suggest a method through which public health nurses may acquaint themselves with the industrial health needs in their communities; to show the part that public health nurses can play in meeting these needs; to point out community health advantages to be gained through the development of public health nursing in industry; and to offer practical suggestions to public health nursing agencies for the promotion of the health of workers through nursing service.

Before interested groups undertake a staff education program on industrial nursing, however, it is advisable for them to consult the industrial hygiene and public health nursing bureaus of their state departments of health, as well as local chambers of commerce, to determine whether an industrial survey has been made which would provide information on the number and type of industries in their community and the health problems associated with these industries.

Additional assistance and informative data concerning local industrial health conditions are available from the Division of Industrial Hygiene, National Institute of Health, United States Public Health Service; state and local industrial hygiene bureaus; the Council on In-

dustrial Health, American Medical Association; the Industrial Hygiene Section, American Public Health Association; and the Committee on Healthful Working Conditions, National Association of Manufacturers. Insurance companies can also supply valuable information. Members of state and city health departments are in a position to recommend qualified persons, such as industrial physicians, engineers, and nurses, to prepare material and to lead discussions concerning industrial health problems.

Visits to industrial plants are a valuable part of the educational program. Since, however, observation trips can be made more meaningful at the end of the study program, it is recommended that they be deferred until that time. During the visits to industries, it is advisable to have hazards and methods of their control brought to the attention of the group by the industrial hygienist or safety engineer. When possible, visits should be made to a group of industrial organizations which offer varied types of health programs to their employees—*e.g.*, services with a full-time physician, with a nurse working alone, or with first-aid workers only.

Today, with abundant reading material available concerning health in industry, industrial nursing, and allied subjects, it is not to be assumed that the accompanying bibliography is exhaustive. Its purpose is to introduce the participants to a few of the many sources which should provide thought-provoking questions, and to stimulate a desire for additional knowledge. By giving special attention to the footnotes and bibliographies in the recommended supplementary reading, students will become familiar with further data.

Much of the reference material may be borrowed from the National Health Library, 1790 Broadway, New York, New York, the use of which is available to members of the National Organization for Public Health Nursing, without additional fee. Reference material may also be obtained from private or public libraries.

The N.O.P.H.N. through its consultant service in industrial nursing will be glad to provide further assistance with staff education programs in industrial nursing and to assist any agency, individual nurse, or employer in developing better nursing service for industrial workers.

## GENERAL INFORMATION ON INDUSTRIAL HYGIENE

### I. What information about the industries in the community would be helpful to the nurse?

#### A. General information concerning the industries in the community

1. Number and types of industries
2. Number of industries employing 500 workers or less
3. Number of industries providing health services
4. Percentage of women workers
5. Predominating age groups
6. Predominating nationalities
7. Predominating labor policies in the community

#### B. Data concerning representative industries in the community

1. Type of industry

- a. Products manufactured
- b. By-products manufactured
2. Health service
  - a. Type—full time or part time
  - b. Scope of activities
3. Rates and causes of absenteeism
  - a. Industrial accidents
  - b. Industrial illnesses
  - c. Nonindustrial accidents
  - d. Nonindustrial illnesses
4. Insurance plans
  - a. Compensation insurance
    - (1) Insurance company
    - (2) Self-insured
    - (3) State insurance
  - b. Benefits
    - (1) Insurance company
    - (2) Mutual benefit association



## II. What are some of the potential industrial hazards in the industries in the community?

### A. Chemical

1. Dusts
2. Fumes
3. Gases
4. Vapors
5. Liquids

### B. Biological

1. Respiratory diseases
2. Chronic diseases

### C. Physical

1. Accidents
2. Noise
3. Abnormal pressure
4. Humidity

## III. How may these hazards be overcome?

### A. Health measures

1. Adequate medical and nursing service
2. Periodic physical examinations to discover symptoms of conditions that may be caused by specific hazards
3. Necessary arrangements for correction of conditions found

### B. Engineering control

1. Plant design
2. Housekeeping
3. General ventilation
4. Substitution of nonhazardous materials for hazardous materials
5. Closed processes
6. Wet methods
7. Local exhaust
8. Personal respiratory and protective equipment
9. General public health control—food, water, and sewage

## IV. What community resources are available to meet the health needs of workers?

### A. Health department

1. Division of industrial hygiene
2. Bureau of public health nursing

### B. Department of labor—industrial commission

### C. Nonofficial health and nursing agencies

### D. Hospitals

### E. Clinics

### F. Recreational facilities

### G. Adult education agencies

### H. Vocational rehabilitation service

### I. Social case work and relief organizations

### J. Other community agencies

## V. What industrial legislation exists for the protection of workers in industry and how is it implemented?

### A. Types

1. Workmen's compensation act covering:
  - a. Accidental injuries
  - b. Occupational disease

2. Legislation to meet specific industrial problems, concerning:
  - a. Wages and hours
  - b. Working conditions
  - c. Child labor
  - d. Women workers

3. Employment security (social security)

### B. Essentials for implementing the laws

1. Adequate funds for administration
2. Adequately trained personnel for carrying out provisions of the laws
3. Understanding and coöperation of the public

## VI. What sources of information on industrial hygiene problems and services are available?

### A. Official health agencies

1. State department of health
2. U. S. Public Health Service, Division of Industrial Hygiene

### B. Labor departments

1. State
2. Federal

### C. Trade associations of employers

1. National Association of Manufacturers
2. National Safety Council
3. National Industrial Conference Board
4. American Foundrymen's Association
5. Industrial Hygiene Foundation

### D. Labor unions

### E. Insurance companies

### F. Professional organizations

1. American Association of Industrial Physicians and Surgeons
2. Councils on Industrial Health
  - a. State medical societies
  - b. American Medical Association
3. National Organization for Public Health Nursing
4. American Public Health Association

## VII. What benefits may be expected from health services in industry?

### A. Intangible benefits

1. Improved industrial relations
2. Improved public relations
3. Better community health

### B. Tangible benefits

1. Increase in efficiency of production
2. Decrease in spoilage
3. Cash benefits
  - a. Lowered taxes, due to decrease in relief expenditures
  - b. Lowered compensation costs
  - c. Lowered insurance rates

**VIII. What are some of the methods of financing part-time nursing service and home visiting service in industry?**

- A. Methods of payment to visiting nurse associations for part-time service in industry
  - 1. Contract between industry and visiting nurse association whereby association is paid for service
    - a. On an hourly basis
    - b. By a stipulated monthly sum
- B. Methods of payment to visiting nurse

associations for service to workers in homes

- 1. Contract between industry and visiting nurse association whereby association is paid for visits
  - a. On an hourly basis
  - b. On a home-visit basis
  - c. By a stipulated monthly sum
- 2. Payment to visiting nurse association by insurance companies for service to group certificate holders
- 3. Payment to visiting nurse association by plant mutual benefit association for service to beneficiaries

**HEALTH SERVICE WITHIN THE PLANT**

**I. What basic provisions for organization and administration are necessary for an effective health service in an industry?**

- A. Administrative direction may be under:
  - 1. Executive office management
  - 2. Personnel office
  - 3. Employment office
- B. Medical direction
  - 1. Full-time physician
  - 2. Part-time physician
  - 3. Physician on call
  - 4. Panel of physicians
- C. Nursing supervision
  - 1. Agency supervision—extent of supervision determined through agreement of plant administrative director, medical director and agency
  - 2. Insurance company nurse supervisor—from home office of insurance company
  - 3. Nurse supervisor employed by the industry
  - 4. Consultant nurse from state agency
    - a. Department of health
      - (1) Division of industrial hygiene
      - (2) Bureau of public health nursing
    - b. Other state agency
- D. Nursing service
  - 1. Full-time nurse
  - 2. Part-time nurse
- E. Nonprofessional service
  - 1. First-aid worker with standard or advanced American Red Cross course
  - 2. Other designated workers
- F. Representative employer-employee committee to develop and promote health program
  - 1. Industrial relations committee
  - 2. Safety and health committee

**II. What facilities are required to meet industrial health needs?**

- A. Quarters
  - 1. Adequate size

- 2. Convenient location
- 3. Adequate light
- 4. Running water
- 5. Toilet facilities
- B. Equipment\*—standard dispensary equipment sufficient for kind and size of industry
- C. Supplies\*—depending on needs of individual plant

**III. What services should be included in a health program for industrial workers?**

- A. First-aid care for injured or ill worker
- B. Re-treatments
- C. Physical examinations
  - 1. Purposes
    - a. Job placement—appraisal of ability, aptitude, and potential endurance
    - b. Health protection of employee through discovery and correction of abnormal conditions
    - c. Protection of employer from legal liability for illness of nonindustrial origin
  - 2. Type
    - a. Preemployment
    - b. Periodic
  - 3. Scope\*\*
- D. Follow-up of abnormal conditions discovered in examination

\*Detailed information on equipment is available in the literature of the Metropolitan Life Insurance Company, 1 Madison Avenue, New York, New York, and the National Association of Manufacturers, 14 West 49 Street, New York, New York.

\*\*The scope of the examination will be determined by the examining physician. Various types of physical examination forms for industrial workers have been prepared by the American College of Surgeons and are available from the Physicians' Record Company, 161 W. Harrison Street, Chicago, Illinois.

## E. Safety and health education

## F. Rehabilitation program—physical, emotional, social, vocational

## G. Recreation—in cooperation with other departments

**IV. What are the nurse's functions in the health program for industrial workers?**

## A. Responsibility for general efficiency of the medical department according to stated policy of the plant

1. Management
2. Equipment
3. Supplies
4. Records

## B. Responsibility for first-aid service and arrangements for such service throughout the plant

1. First-aid treatment under medical standing orders
2. Training of first-aid workers
3. Supervision of first-aid kits and supplies

## C. Assistance with physical examinations and tests—acting on written standing orders during physician's absence

1. Taking of histories—disease, occupational, and family history
2. Vision and hearing tests\*
3. Laboratory tests—collection of specimens, examination of specimens
  - a. Urinalysis
  - b. Serology
4. Measurement of blood pressure
5. Assistance with x-ray examination

## D. Follow-up of abnormal conditions discovered in physical examination

1. Conference with employees on individual and family health problems and general health practices
2. Referral of employee to physician, dentist, or community agency

## E. Responsibility for health and safety education throughout the industry

1. Teaching of disease prevention and desirable health practices
  - a. Individual teaching
  - b. Group teaching—classes, meetings
  - c. Through general channels of health education—use of bulletin boards, literature, movies, company house organ, and posters
2. Assistance in interpretation to employer

and employees of general safety and health program in plant through:

- a. Good plant housekeeping
- b. Illumination
- c. Ventilation
- d. Sanitation
- e. Recreational program

## 3. Consultation with manager of factory lunchroom regarding:

- a. Balanced menus
- b. Sanitation
- c. Appearance

## F. Coordination of industrial health services with other services

## 1. Within the plant

- a. Safety department
- b. Personnel department
- c. Rehabilitation service
- d. Committee on recreation

## 2. Within the community (See under IV, page 3.)

**V. What are some of the principles to be followed in rendering health service in industry?**

## A. Professional aspects

1. All service rendered in accordance with written, approved standing orders
2. Service rendered in accordance with accepted nursing practice
3. Service rendered with skill and judgment

## B. Legal aspects—service rendered so as to assure protection of employer, worker, and health personnel

## C. Educational aspects—service planned with following aims

1. Development of worker responsibility
2. Development of appreciation of medical services
3. Prevention of accidents and illnesses

## D. Relationships—referral of significant information to other departments in the plant (see under F above.)

**VI. What types of records and reports may be used in industry and why are they necessary?**

## A. Types of records and reports

## 1. Service records of individual employees

- a. Physical examination
- b. Absentee records
  - (1) Noncompensable illnesses or injuries
  - (2) Compensable illnesses or injuries

## 2. Reports to management

- a. Periodic reports
- b. Special reports to management, illustrated by charts and graphs, showing
  - (1) Health problems of the industry
  - (2) Health accomplishments

\*For information on vision tests and various aspects of eye health, write the National Society for the Prevention of Blindness, 1790 Broadway, New York, N.Y.

For information regarding hearing tests write the American Society for the Hard of Hearing, 1537 35 Street, N. W., Washington, D. C.

- (3) Meetings attended by nurse
- (4) Use of community resources to meet needs of workers

#### B. Objectives

##### 1. Records

- a. To promote continuity of care through providing an account of services given by the nurse to the worker or family
- b. To make available accurate information for compensation cases

##### 2. Reports

- a. To show the volume and types of service rendered to workers
- b. To interpret the health needs and program to management
- c. To justify expenditures
- d. To show growth and changes in service
- e. To serve as a basis for measures to prevent illness and accidents

### NURSING SERVICE TO WORKERS IN THEIR HOMES

#### I. What information is necessary for the referral of workers to the visiting nurse associations?

##### A. Facts to be supplied to the industry regarding the nursing agency

- 1. Name, address, and telephone number
- 2. Type of service offered by the agency
- 3. Hours during which service is available
- 4. When to report calls
- 5. How to report calls
  - a. Telephone
  - b. Writing
  - c. Personal message

##### B. Facts to be supplied to the visiting nurse association regarding patient referred

- 1. Name, address, and telephone number of patient
- 2. Complaint
- 3. Eligibility for service under insurance plan or by other plan
  - a. Employee only
  - b. Members of family

#### II. What are possible methods of referring workers to the visiting nurse association for care in the home?

##### A. Arrangement to inform key persons in the industry about the nursing agency and make them responsible for referring workers

- 1. Nurse
- 2. Personnel manager
- 3. Superintendent or foreman
- 4. Office manager
- 5. First-aid worker
- 6. Telephone operator

##### B. Direct referral by

- 1. Employee
- 2. Member of family
- 3. Family physician
- 4. Insurance agent

#### III. What are methods of stimulating interest of the employer in nursing services for workers in the home?

##### A. Periodic contacts by the nurse with the employer

##### B. Reports to employer of interesting cases

##### C. Monthly or annual reports to employer of services rendered by the agency

#### IV. What are methods of stimulating interest of the employees in the service?

##### A. Posters

##### B. Literature

##### C. Announcements on bulletin board

##### D. Pay-roll inserts

##### E. Publicity in bulletin or trade paper

##### F. Periodic talks by nursing representative

#### V. What is the visiting nurse's responsibility to physicians?

##### A. Nurse's responsibility to the company physician—when patient is not under the care of a private physician

- 1. To carry out individual medical orders
- 2. To secure standing orders
- 3. To report back to the physician

##### B. Nurse's responsibility to the patient's private physician

- 1. To carry out individual medical orders
- 2. To follow standing orders of agency until individual orders can be secured
- 3. To report back to physician
- 4. To refer employer directly to physician for diagnosis or secure permission to supply diagnosis to employer when requested

#### VI. What are some of the benefits available to the visiting nurse association resulting from having contracts with industrial organizations?

##### A. Contacts with heads of families

##### B. Increased opportunity to work with individuals exposed to various health hazards

##### C. Opportunity to broaden contacts with influential persons in the community

##### D. Opportunity to act as a liaison between employee, employer, and community, to improve:

- 1. Employer-employee relationships
- 2. Working conditions in the plant

3. Home conditions of workers—including housing

4. Community health program

F. Opportunity to guide and stimulate the employee to assume responsibility for accident prevention and health promotion in home, industry, and community

#### VII. What should be included in reports to the industry regarding employees visited in the home?

A. Should reveal diagnosis only when approved by attending physician and employee

B. Should keep employer informed of severity of illness, its possible duration, and probable length of absence from work

C. Should contain interpretation of special problems affecting the health and welfare of the worker, his family, or the community

1. Home conditions

2. Need for financial aid

3. Need for hospitalization

4. Other problems

This outline was prepared by the staff of the National Organization for Public Health Nursing with the assistance of staffs of other agencies interested in industrial nursing. Initial work in assembling the material was done by D. Irene Bigler, industrial nursing consultant of the N.O.P.H.N.

Assistance in the preparation and checking of material was given by Olive M. Whitlock, public health nursing consultant, and by technical advisers in the Division of Industrial Hygiene, National Institute of Health, U. S. Public Health Service; by members of the staff of the Nursing Bureau, Metropolitan Life Insurance Company; and by Joanna M. Johnson, supervisor, Industrial Nursing Department of Employers Mutuals of Wausau, Wisconsin.

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## THE AMERICAN JOURNAL OF NURSING FOR JANUARY

Recruitment of Student Nurses

Progress Report on the National Survey of Registered Nurses

Blood Serum and Plasma Transfusions..... Sidney O. Levinson, M.D., and Robert Finkelstein

Nursing and National Defense..... Annie W. Goodrich, R.N.

Foreign Bodies in the Eye..... Murray F. McCaslin, M.D.

Our Speakers' Bureau..... Margaret Reid, R.N.

The Tracheotomy Patient..... Georgia Long Gillespie, R.N.

Chemotherapy in Gonorrhea..... George W. Slaughter, M.D., and Philmor Simon, R.N.

Nursing in Tuberculosis..... E. S. Mariette, M.D.

The Spastic Child..... Helen M. Curtis, R.N.

Psychiatric Nursing Case Studies..... Lucile Scott, R.N., and Margarita DeCamp, R.N.

The Hospital Project of the NYA..... Marie Lane

# Defense of the Nation's Health

## NURSING DEFENSE COUNCILS

**F**ORTY-SIX STATES and the District of Columbia have organized nursing councils on defense. The formation of these councils is welcomed by the three agencies primarily concerned with nursing in defense—the Subcommittee on Nursing of the Health and Medical Committee, Office of Defense Health and Welfare Services; the Medical Division of the U. S. Office of Civilian Defense; and the Nursing Council on National Defense. It is hoped that through them a large part of the defense program can be carried on. Many tasks are waiting to be done and the help of all local nursing groups will be needed. The performance of these tasks by nurses acting as a united group in each state will save confusion and duplication of effort on the part of both national and local units.

The Committee on the Recruitment of Student Nurses has asked for the right of way and is the first group to send instructions and working materials to these state nursing councils on defense. An intensive drive for highly qualified young women to enter the nursing profession is under way for the month of January. It is hoped that each state will supply its local units with this material so that they may help effectively in reaching the goal set—50,000 students in schools of nursing. An excellent Speaker's Kit has been assembled and detailed directions for the recruitment program are available.

A clarion call has gone out to every women's college and junior college, enlisting their help in arousing the interest of their senior students in the opportunities to be found in the nursing profession.

Radio, newspapers, and magazines are all being used as channels for publicity. Many popular magazines, college and

sorority publications, local high school bulletins, and newspapers in small and large cities will carry the appeal to young women to enter a profession that is being called upon for defense work beyond its capacity to respond. Radio transcriptions will soon be ready for all local stations. Spot announcements describing the need for both students and graduate nurses for the Red Cross First Reserve are being broadcast through government channels. This recruitment program for student nurses is a joint effort of the Subcommittee on Nursing and the Nursing Council on National Defense.

## RED CROSS MEDICAL DIRECTOR

**D**R. ALBERT McCOWN has been appointed director of medical and health service of the American Red Cross to succeed Dr. William DeKleine, who retired September 1 after 14 years of service. Dr. McCown has formerly held positions as director of the Child Health Division, Washington State Department of Health; director of the Division of Maternal and Child Health, U. S. Children's Bureau; and deputy commissioner of health of the Michigan State Department of Health, Lansing. He was director of the research and training unit, Bureau of Child Hygiene, New York City Department of Health in 1940 and 1941.

## GIGANTIC RED CROSS PROGRAM

**T**HE American Red Cross has launched an appeal for a minimum \$50,000,000 American war relief fund, and a proclamation has been issued by President Roosevelt calling on the country to respond to the appeal. The fund is needed to provide relief for civilian populations bombed from their homes by the Japanese and for those who are un-

der threat of enemy action in the Pacific war emergency or upon the continent of the United States; and to make possible the necessary welfare work of the Red Cross for men in the armed forces and their families. The 3700 Red Cross chapters have been given quotas which their communities are asked to contribute.

The program for civilian defense has as a goal the training of a million citizens in first aid, with emphasis on care of war gas cases, control of bleeding, transportation of wounded, and other first-aid problems of war; the training of a half million each in home nursing and nutrition; and the preparation of one hundred thousand each as volunteer nurse's aides and nutrition aides.

The Red Cross is also making a collection of blood from volunteer donors for blood plasma for our Army and Navy and injured civilians, for which millions of blood donors will be needed. Its program calls for a tremendous increase in the production by volunteers of surgical dressings for our hospitals, and sweaters, garments, and other comfort articles for our soldiers and sailors as well as civilian victims of the war.

#### VOLUNTEER NURSE'S AIDES

**A** SYLLABUS of a course of instruction for Volunteer Nurse's Aides, as revised with the collaboration of the Medical Division of the U. S. Office of Civilian Defense, has been prepared by the American National Red Cross, Washington, D. C. The syllabus, published in August 1941, is a revision of the material which has been used by instructors of Red Cross courses for Volunteer Nurse's Aides since July 1940. The revised course provides for 80 hours of intensive training over a period of seven weeks. The first half of the course, consisting of lectures and dem-

onstrations, is to be given at the local Red Cross chapter house or other suitable place; the second half will be supervised practice in a hospital designated by the Office of Civilian Defense and the American Red Cross as a training center.

Nurse's aides will work under the supervision of a nurse at all times in hospitals, clinics, and community health agencies. They will serve on a volunteer basis without pay and are not to supplant paid workers. Plans call for the training of 100,000 Aides to meet the expanding need of hospitals and health agencies during the national emergency.

#### SPECIAL DEFENSE COMMITTEES

**T**HE Subcommittee on Nursing of the Health and Medical Committee, Office of Defense Health and Welfare Services, has two new special committees which are already busy at their appointed tasks.

A Special Committee on Army and Navy Nursing has as its objective to review educational and recreational opportunities for Army and Navy nurses. Appointed to this committee are Gertrude Banfield, chairman, Mrs. Alma H. Scott, Sue S. Dauser, Mrs. Julia O. Flikke, and Alma C. Haupt.

A Special Committee on the National Survey of Registered Nurses has been appointed with the following members: Marian G. Randall, chairman, Ella G. Best, Virginia Dunbar, Ruth Houlton, Blanche Pfefferkorn, Pearl McIver, Elmira Bears Wickenden, Alma C. Haupt.

#### NATIONAL SOCIAL HYGIENE DAY

"Keep America Strong—Help Build Better Health" is the theme of the Sixth National Social Hygiene Day, to be observed on Wednesday, February 4, 1942. The American Social Hygiene Association, which sponsors the event, is leading the nation's fight against syphilis

and gonorrhea, both grave threats to national health and strength. Social Hygiene Day folders describing the observance and suggesting activities for cooperating groups are available from the Association, 1790 Broadway, New York, N. Y.

#### WHAT CAN I DO?

THE GENERAL public is making an increasing demand for Red Cross classes in Home Nursing due to the joint efforts of the Office of Civilian Defense and the American Red Cross to stimulate interest in these courses. Public health nurses, and indeed all nurses qualified to teach and authorized by the American Red Cross to do so, can make an invaluable contribution in their own communities through the teaching of home nursing.

Requests for authorization to teach the course should be made directly to your local Red Cross chapter or to the area headquarters. (See page 61 of this issue.) Although enrollment in the Red Cross Nursing Service is desirable, at the present time it is not a prerequisite for authorization to teach the course. If the applicant meets the professional and academic qualifications, an authorization card and aids in teaching are sent her.

The local chapter of the American Red Cross is prepared to help each instructor through its Home Nursing Committee. It is this committee's responsibility to recruit and arrange for the classes, provide a meeting place, assemble the essential equipment as requested by the instructor, and help her as needed in each local situation. In chapters where there is no Home Nursing Committee prepared to give this assistance, the nurse should take the initiative and discuss the problems with the chapter chairman, who with the chapter executive committee is responsible for the appointment of the Home Nursing chairman.

Public health nurses can best help in

their own communities by giving professional service which non-nursing personnel are not equipped to give. Group teaching is one of the most effective tools which can be used by the public health nurse for safeguarding community health at this time when the health of the nation is its greatest strength.

#### Women and Petrol

*(Continued from page 21)*

for carriers and missed cases and to give service in the homes. Station wagons are used for long trips only, because of gasoline shortage.

Dr. Gordon believes that "man and petrol" (in this instance it perhaps comes closer to being women and petrol) form the core of successful epidemiological work rather than elaborate equipment. He thinks field nurses should have well rounded training in all parts of epidemiological work—collection of data, writing of reports, making of graphs and analysis of results—so that they will understand the significance of their field work.

The field nurses in the Unit have done a variety of types of work; assistance in air-raid shelters; emergency duty in child health clinics, hospitals, public health clinics, and as health visitors in organized health departments; care of evacuated children; assistance with the river nursing service up and down the Thames. Two are now living in the "pub" of a picturesque rural village where there is an epidemic of infectious jaundice. In rural areas such as this the nurse sets up her office and record system, living the life of the village and assisting the local health officer by her work in the homes.

Three letters by Elisabeth C. Phillips, associate chief nurse in charge of public health nursing for the Unit, were published in the September, November, and December issues of this magazine.

P.P.



## NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

MISS HILBERT

COMES

TO THE

N.O.P.H.N.



*Photo by Bachrach*

It is with great satisfaction that we announce the appointment of Hortense Hilbert as the new associate director of the National Organization for Public Health Nursing. Miss Hilbert comes to the N.O.P.H.N. from the United States Children's Bureau, in which she has been a public health nursing consultant since 1936. She was previously a member of the N.O.P.H.N. staff when she was lent by the American Child Health Association in 1931 to assist with the Survey of Public Health Nursing.

Miss Hilbert brings a broad and rich background to her new position. She has her B.A. degree from the University of Minnesota, and is a graduate of its school of nursing. She has had post-graduate work in pediatric and psychiatric nursing at Johns Hopkins University, Baltimore, Maryland. In Minnesota her experience included field nursing in the Infant Welfare Society of Minneapolis; poliomyelitis after-care

for the State Board of Control; and public health nursing advisory service in the Child Hygiene and Venereal Disease Divisions of the State Department of Health. For more than four years Miss Hilbert served as assistant director of the Austrian child health demonstration conducted by The Commonwealth Fund. Upon her return to the United States, she joined the staff of the American Child Health Association in the capacity of public health nursing consultant, and subsequently served for a year as an administrative supervisor in a Home Relief Bureau in New York City.

Miss Hilbert's varied experience in both official and non-official agencies both here and abroad and her keen, analytical mind will do much to promote the interests of the N.O.P.H.N. and the cause of public health nursing in the United States. She will assume her new duties on February 1. R.H.

### FIELD SERVICE

The December field trips of the N.O.P.H.N. staff included visits to Illinois, New York, Pennsylvania, and Washington, D. C.

At the invitation of the director of public health in Illinois, Dorothy Deming participated in a special luncheon for public health nurses at the annual Illinois Conference on Public Health which took place in Springfield on December 5. Miss Deming's contribution was a talk on the timely subject "Public Health Nursing in Defense." On the same day she also met with the Board of Directors of the Public Health Nursing and Tuberculosis Association of Sangamon County, Springfield.

On December 1 and 2, Jessie Stevenson went to Washington, D. C. to attend meetings of the Children's Bureau Advisory Committee on Maternal and Child Health Services, and the Advisory Committee on Crippled Children's Services. She is a member of both of these advisory committees.

For the past seven years, annual regional conferences of public health nursing executives have been held throughout the country. This year's conference was in Reading, Pennsylvania on December 4 and 5. The N.O.P.H.N. representative at the meeting was Anna Gring, who acted as chairman of the session on agency services.

The growing interest among visiting nurse associations in the possibilities of nursing service to small industries stimulated the Visiting Nurse Association in Syracuse, New York, to invite D. Irene Bigler to speak on this subject at its December Board meeting. While she was in Syracuse Mrs. Bigler also spoke on the health education of employees at a luncheon of the Nursing Section of the Council of Social Agencies. On this New York State trip she also visited Albany, spending a day of observation in a number of industrial establishments and participating in the industrial nurs-

ing program of a two-day institute held by the Capital District Number Nine, New York State Nurses Association.

### MISS GRING GOES TO RED CROSS

The N.O.P.H.N. announces with regret the resignation of Anna C. Gring who, as assistant director since 1939, has guided the work of the School Nursing Section, edited the Book Notes department of PUBLIC HEALTH NURSING, and assisted with our biennial conventions. Miss Gring is leaving January 1 to accept a position with the American Red Cross in Washington as assistant to the director of the Red Cross Nursing Service, to serve as educational assistant in home nursing.

Thanks to Miss Gring, the committees of the School Nursing Section are engaged in exceedingly useful studies. Among these are the studies of the place and function of nurses in colleges and of camp nurses; and the preparation of material enriching the school nurse's home visit. The individual school health record was published this year, and a leaflet, "The Nurse in the School Health Program," has been prepared under the guidance of the newly appointed Joint Committee on Lay Participation in School Nursing. Miss Gring's assistance on the magazine will be sorely missed.

Her new responsibilities are in a field crying for assistance and her experience gives her an excellent background for understanding the needs of instructors of Home Nursing classes. She has conducted conferences and institutes for instructors, and has taught the Red Cross teacher-training course at the University of Pennsylvania.

We see her leave our staff with regret, but with the conviction that this is not a time to withhold ability such as hers which is so greatly needed by the American Red Cross in this particular field and to which she has a special contribution to make. Our best wishes go with her for success and happiness. D.D.

## ATTEND A GROUP CONFERENCE AT THE BIENNIAL

THE N.O.P.H.N. is planning a series of group conferences on various subjects on Saturday and Sunday, May 16 and 17, just preceding the Biennial Convention in Chicago. The following conferences will be given:

**Business Administration.** Leader to be announced later. Open to from 30 to 60 people, representatives from member agencies of the N.O.P.H.N., preferably business managers or directors. Only one representative from each member agency may attend.

Sessions: Saturday, May 16, all day.

Registration fee: \$2.

**Eye Health.** Leader, Eleanor W. Mumford, associate for nursing activities, National Society for the Prevention of Blindness, New York, New York. Open to from 6 to 35 supervisors or instructors in public health nursing; course or educational directors; instructors, supervisors, or head nurses in eye services in schools of nursing; and public health nurses who have special responsibilities in eye programs.

Sessions: Saturday, May 16, all day.

Sunday, May 17, a. m.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

**Industrial Nursing.** Leader, D. Irene Bigler, industrial nursing consultant, National Organization for Public Health Nursing. Open to from 30 to 60 nurses.

Sessions: Saturday, May 16, all day.

Sunday, May 17, a. m.

No registration fee.

**Methods of Group Teaching.** Leader, Frances H. Benjamin, State Department of Health, Lansing, Michigan. Open to 35 nurses actively engaged in group teaching.

Sessions: Saturday, May 16, all day.

Sunday, May 17, a. m.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

**Nutrition.** Leader to be announced later. Open to 40 nurses.

Sessions: Saturday, May 16, all day.

Sunday, May 17, a. m.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

### Orthopedic Nursing.

**Section A.** Conference for head nurses, supervisors, and instructors in orthopedic services in hospitals. Leader, Carmelita Calderwood, N.L.N.E. nursing consultant, Joint Orthopedic Nursing Advisory Service.

**Section B.** In this conference preference will be given to public health nurses actively engaged in orthopedic services in local agencies, and to nurses responsible for the general staff education program. Leader, Jessie L. Stevenson, N.O.P.H.N. nursing consultant, Joint Orthopedic Nursing Advisory Service.

Each conference is limited to 30 nurses. A joint session of both groups will be held Sunday morning.

Sessions: Saturday, May 16, all day.

Sunday, May 17, a. m.

No registration fee.

### School Nursing.

**Section A.** Conference for nurses in the elementary schools. Leader, Lula P. Dilworth, associate in health and safety education, State Department of Public Instruction, Trenton, New Jersey.

**Section B.** Conference for nurses in the secondary schools. Leader, Gertrude E. Cromwell, supervisor, health education and school nursing, Des Moines Public Schools, Des Moines, Iowa.

Each conference is open to from 30 to 60 nurses.

Sessions: Saturday, May 16, all day.

Sunday, May 17, a. m.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

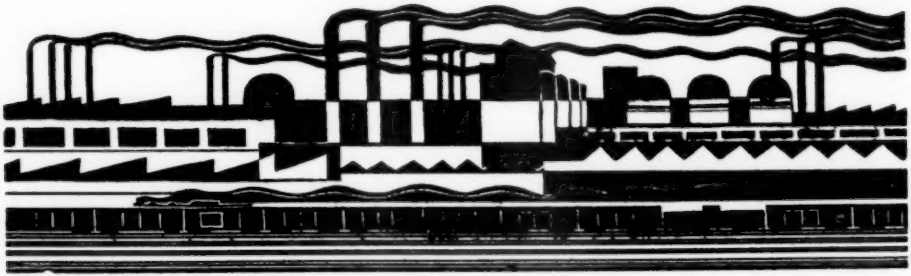
**Social Hygiene.** Leader to be announced later. Open to from 30 to 60 nurses.

Sessions: Saturday, May 16, all day.

Sunday, May 17, a. m.

Registration fee: \$2 to N.O.P.H.N. members; \$4 to nonmembers.

Registrations stating name, address, position, N.O.P.H.N. membership if a member, name of institute, and registration fee should reach the N.O.P.H.N. office, 1790 Broadway, New York, N. Y., before May 1. Registrations will be accepted in order of application and notification will be sent of acceptance. Inquire at the N.O.P.H.N. information desk at the Palmer House for the room assignment of your group conference.



## NATIONAL SAFETY CONGRESS

WITH THE KEYNOTE, "Help Defense—Stop Accidents," the Thirtieth National Safety Congress and Exposition was held in Chicago, October 6-10. It was attended by some ten thousand delegates, representing every state in the Union. The importance of safety to defense gave special significance to the meetings this year, when the conservation of both man power and materials has become more vital to the nation than ever before, and plans for intensive nationwide campaigns against accidents will be necessary if production schedules are to be met.

Officers of the Council responded to the safety proclamation issued by President Roosevelt on August 18 by preparing new and more effective plans for

defense promotion through accident prevention. There was confidence that through the concerted effort of every organization, every business concern, and every individual, the accident curve could be turned downward.

The sessions of the Industrial Nursing Section held on October 8 and 9 were unusually well attended. Problems of immediate concern to the industrial nurse were discussed in excellent papers on the keeping and use of records, the effects of dental infections among industrial workers, the nurse's part in reducing absenteeism, employee health education, and the opportunities for integrating industrial health services with community health programs.

D.I.B.

## COMMUNICABLE DISEASES IN DEFENSE AREA

THE INFLUX of large numbers of workers into areas where new defense industries have been constructed or old industries expanded has tended to aggravate the problem of communicable disease control. In order to show how a state or local industrial hygiene bureau can help to solve the problem, a procedure now being used in Baltimore, Maryland, is described.

Large numbers of industrial workers have been coming to Baltimore from sections of the country where smallpox vaccination, typhoid inoculation, and the use of diphtheria toxoid are not com-

monly practiced. The city health department therefore was confronted with the problem of reaching these new residents in order to urge upon them the importance of preventive measures for individual and community health protection. The best points of contact obviously were the employment offices of defense industries, and the industrial hygienists in the city health department were best acquainted with the persons in charge of such offices. Return postcards, providing space for name, address, and number of children, were printed and the industrial hygienists took supplies of these

cards to personnel managers and arranged to have them filled out and mailed to the Bureau of Communicable Diseases. Contact was also made with the State Employment Office.

The completed cards are turned over to the Bureau of Public Health Nursing, and visits are made by members of this bureau to the home of each newcomer to

the city. Up to September 1, nearly 18,000 cards had been distributed to 35 firms. The distribution is being continued, and completed cards are being returned in increasing numbers.

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From *Industrial Hygiene*, September 1941, Division of Industrial Hygiene, National Institute of Health, United States Public Health Service, Washington, D.C.

### NEW SUPPLEMENT FOR NURSES

A NEW MEDIUM for exchange of experiences and problems between industrial nurses was launched with the initiation of a quarterly supplement under the title "Industrial Nurse," by Industrial Medicine, 540 North Michigan Avenue, Chicago. The supplement, which appeared in November, will be

published quarterly. PUBLIC HEALTH NURSING welcomes the supplement as an additional source of professional material for nurses working in industry, believing that it is another indication of the growing importance of this expanding field of health service. Our best wishes for its success!

### TWO MORE PAMPHLETS FOR WORKERS

CARBON MONOXIDE gas and benzol, both common industrial hazards, are the subject of two additional popular leaflets for workers in the Workers' Health Series published by the U. S. Public Health Service. These attractive little pamphlets published under the titles of "Clara gives BENZOL the run

around," and "K O by C O gas"—are written in direct, readable style, in large type with amusing illustrations similar to others in the series.

The pamphlets in this series may be purchased at a small cost from the Superintendent of Documents, Government Printing Office, Washington, D. C.

### PROTECTION OF DEFENSE WORKERS

INDUSTRIAL HYGIENE becomes increasingly important as production of war materials is stepped up. The U. S. Public Health Service therefore directs its industrial hygiene activities particularly toward the protection of defense workers. Engineering and medical studies of health hazards have been made by the Division of Industrial Hygiene in 30 government-owned and operated industrial establishments. In addition, state and local industrial hygiene agencies are concentrating their efforts in establish-

ments producing all kinds of defense material—including aircraft, ships, military vehicles, and munitions. For the period July to November, 1941, some 25 states have reported on surveys and engineering or medical studies in 1500 establishments involving more than 600,000 workers. Various recommendations for the improvement of the working environment have been made affecting 150,000 workers, and to date, have been carried out for 55 percent of these workers.





EDITED BY ANNA C. GRING

#### ORIENTATION IN SCHOOL HEALTH

By Clair V. Langton, Dr.P.H. 680 pp. Harper and Brothers, New York, 1941. \$3.

As a teacher-training textbook, this book is surpassed by none which the reviewer has seen to date. It is complete and interesting, and should be stimulating to future teachers.

As a handbook or refresher for administrators, it would seem to be a little long and somewhat heavy. The areas dealing with the school plant, communicable disease, and nutrition are of sufficient importance to warrant handbooks dealing with each of these subjects in more complete detail than is given here. It might be sufficient to mention only the most fundamental facts concerning them in this book, and to present at somewhat greater length the school's responsibility in these areas. However, the book should contribute greatly to the thinking of anybody who is truly interested in improving the school health program.

The book includes an introduction on the philosophy of school health; a section on prevention and control of communicable disease; one on healthful school living; one on the hygiene of the school child; and the last one on the teacher, the curriculum, and school health. In all of these sections the author is essentially sound, and has produced a book well worth owning by

general school administrators and especially by school health workers.

GERTRUDE E. CROMWELL, R.N.  
*Des Moines, Iowa*

#### NURSING IN PREVENTION AND CONTROL OF TUBERCULOSIS

By H. W. Hetherington, M.D., and Fannie Eshleman, R.N. 316 pp. G. P. Putnam's Sons, New York, 1941. \$3.

This is a very satisfactory book for the nurse. It covers the many aspects of tuberculosis thoroughly, and emphasizes essential points without going into too much tedious detail. Of particular interest are the chapters on Tuberculosis and Pregnancy, Tuberculosis Case-Finding, and The Prevention of Contagion.

Because of the well ordered arrangement of material and the use of frequent subheads, the book is easy to read and to assimilate. The accompanying illustrations and charts are interesting and pertinent. Those who are using the book as a text for teaching purposes will find the questions and selected references at the end of each chapter helpful.

The authors have made a valuable contribution to our nursing literature, and every public health nurse will do well to make the material presented here an integral part of her working knowledge and skills.

DOROTHY J. CARTER, R.N.  
*Boston, Massachusetts*

**SCHOOL HEALTH SERVICES**

By W. Frank Walker and Carolina R. Randolph.  
172 pp. The Commonwealth Fund, New York,  
1941. \$1.50.

As the subtitle indicates, this is a study of the school health program in six counties in Tennessee, where the school health service is an integral part of the generalized, full-time county health department program. The report deals with more than 56,000 school records for children from six to sixteen years of age during the years 1930-1936. It is a detailed, carefully considered analysis which will repay reading by all those interested or engaged in school health work as well as those in public health work generally. All too often, health agencies continue certain routines for many years without bothering to analyze the results or to evaluate the work in any way. Workers in school health services ought certainly to read this report and ponder it thoughtfully. It is not a difficult work to read and although it contains a large number of tables, both in the body of the report and in the appendices, I trust that no school nurse will be intimidated by them. Emphasis is placed on the advantages of preschool supervision and the presence of parents at the time of physical examinations in schools. While these two factors appear to lead to greater correction of defects found, it is definitely shown that repeated or multiple examinations have in themselves little effect on correction of defects.

The Commonwealth Fund deserves commendation for its aid in making this study possible and the report available. The book brings out so clearly the need for a school health program that is flexible rather than static. No better evidence could be adduced that required annual examinations for all school children are neither feasible nor advisable. Nothing is said in the report, however, about endeavoring to get the school children examined by their own physicians.

Some issue might also be taken with

the authors' interpretation of the general principles of school health service. If the school health examination is to be considered as chiefly educational, it would seem that more would be gained if parents were dealt with in groups rather than as individuals. First of all, parents might be given an understanding not only of the value of a physical examination, but also the limitations of a restricted examination such as children get in school. It seems hardly sound to stress the educational value of school health examinations without emphasizing also to parents as well as to public health officials the necessary shortcomings and the limitations of school examinations.

A. CLEMENT SILVERMAN, M.D.  
*Syracuse, New York*

**THE PUBLIC HEALTH NURSE IN ACTION**

By Marguerite Wales, R.N. 437 pp. The Macmillan Company, New York, 1941. \$2.75.

Written in case history form as a collection of many family health studies gathered from many agencies, this book is interpolated with notes in italics calling attention to the special point or principle the author wishes to illustrate.

Since the book is intended primarily for students in nursing, both undergraduate and graduate, who are preparing to specialize in public health work, the form in which it is presented is particularly appropriate. Instructors in schools of nursing and students of public health nursing will find much reference material for various phases of family health work. For the most part the emphasis throughout the book is on the satisfactory handling of the home problem by the nurse, with commendatory solutions of the problems. Some reference is made, however, to situations where the nurse failed to see opportunities which she might have utilized had she been aware of them.

This departure from the more ideal situations serves to attach to the book a

greater degree of reality than it could otherwise have done. It is hoped too, that this will help to give the young student nurse a more realistic picture than too rosy a painting would portray.

The story fashion in which the various phases of public health nursing are presented serves to hold the interest of the experienced reader also. Some of us might wish that the print were larger. However, it is a readable book, of value to all professional workers who are interested in the activities of the public health nurse in community health work.

HELEN BEAN, R.N.  
*New Orleans, Louisiana*

#### PULMONARY DISEASES IN THE MINING INDUSTRY

By R. R. Sayers, Director. 26 pp. United States Department of the Interior, Bureau of Mines, Washington, D. C., revised 1941. Free.

This circular is a complete and valuable summary of information on general and specific occupational diseases found among our coal and metal miners. It includes clinical, statistical, and control data. The summary at the end is a valu-

able statement covering the whole subject of pulmonary diseases among miners. This mimeographed circular is highly recommended to those who are interested in or concerned with this subject.

ANTHONY J. LANZA, M.D.  
*New York, N. Y.*

#### ANNUAL REPORTS AND HOW TO IMPROVE THEM

Edited by Mary Swain Routzahn. 20 pp. Social Work Publicity Council, New York, 1941. 50c.

This is an excellent bulletin prepared by the Social Work Publicity Council. Its introduction says: "Today, there seems to be a general agreement that a really good annual report . . . not only reports on a year's work, but interprets that year's work as well."

The bulletin gives very practical suggestions on ways of making the report a good one, both from the standpoint of facts and interpretation. It consists of several case histories of annual reports, which should offer good suggestions to local agencies when they are preparing their own.

E. K. D.

### RECENT PUBLICATIONS AND CURRENT PERIODICALS

#### SOCIAL HYGIENE

DIRECTORY OF VENEREAL DISEASE CLINICS. Supplement No. 4 to Venereal Disease Information, United States Public Health Service, Superintendent of Documents, Washington, D. C., 1941. 107 pp. 15c.

Public health nurses will find this directory useful in referring persons for diagnosis and treatment of gonorrhea and syphilis, and for transferring patients under treatment from one community to another. The listing is by state and municipality with information as to whether treatment is provided free or on a pay or part-pay basis.

MODERN SEROLOGIC TESTS FOR SYPHILIS. Josephine Henrichsen, M.D. United States Public Health Service, Superintendent of Documents, Washington, D. C., 1941. 81 pp. 15c.

A scientific treatise on the tests for syphilis

which have been most firmly established in the United States and which have been shown to have definite value.

HEALTH FOR MAN AND BOY. WOMEN AND THEIR HEALTH. MARRIAGE AND PARENTHOOD. 15 pp. each. William F. Snow, M.D. American Social Hygiene Association, 1790 Broadway, New York, 1941. 10c each. 25c for set of three.

#### INDUSTRIAL

THE RESPONSIBILITY OF THE NURSING PROFESSION IN INDUSTRIAL HYGIENE. By J. J. Bloomfield, United States Government Printing Office, Washington, D. C. Superintendent of Documents, 1941. 12 pp. 5c.

Industrial hygiene problems, and suggestions for meeting such problems, and the role of the public health nurse in maintaining employee health are discussed in this booklet.

## NEWS NOTES

- The National Health Council is undertaking a comprehensive, three-year study of the activities of private health agencies in the United States, under a special grant of \$75,000 from the Rockefeller Foundation. The Foundation has given a leave of absence to its vice-president, Mr. Selskar M. Gunn, who has an international background of experience in public health, to direct this study. Mr. Gunn recently returned to America from Paris where he was director of the European headquarters of the Rockefeller Foundation until it was closed because of the war. Previously he was in charge of the Foundation program of rural reconstruction in China. The study will cover important questions regarding the place of the voluntary agency in the public health program and their relationship with official agencies.

- Negro History Week, sponsored by the Association for the Study of Negro Life and History, will be celebrated the week of February 8-15. The purposes of the Association, founded in 1915, are to collect sociological and historical data, to publish books on Negro life and history, to promote the study of the Negro through clubs and schools, and to bring about harmony between the races by interpreting the one to the other. Posters and other literature bearing upon the celebration may be obtained free of charge. For further information write Mr. Carter G. Woodson, 1538 Ninth Street, N. W., Washington, D. C.

- The fourth annual Congress on Industrial Health, sponsored by the American Medical Association will be held January 12-13, 1942 at the Palmer House in Chicago. There is no registration fee. The program for the Congress

is published in the Organization Section of the *Journal of the American Medical Association* for December 6, 1941. Nurses will be interested especially in the dinner and round table on January 12 at 6:30 p. m. The program for this meeting includes a discussion of the use of visiting nurses in industry by Joanna Johnson, chairman of the Industrial Nursing Section of the National Organization for Public Health Nursing.

- A new slide film on housing, "Yes We Can Have Housing," has been produced by the United States Housing Authority. A copy of the film, composed of 80 pictures on the housing problem, what is being done, and what needs to be done about it, is available together with accompanying speech notes from Photo Lab, Inc., 3825 Georgia Avenue, N.W., Washington, D.C. for 75 cents. The film gives special emphasis to the relationship between housing and health, and indicates the important role of community workers, especially public health officers, in the movement for more and better housing. Suggestions on combining parts of the film with local pictures and data to make an illustrated lecture on housing are obtainable from the Information Division, United States Housing Authority, Washington, D.C.

- A section on films in health education and medicine has been established at the American Film Center, an educational organization supported by the Rockefeller Foundation, and located at 45 Rockefeller Plaza, New York, N. Y. The new section, which has received a three-year grant from the Rockefeller Foundation, will be a clearing house and information center on the use and production of these films.

Existing health films will be evaluated

in collaboration with health experts, and lists of recommended films will be published from time to time. Coöperation with the many groups using health films will be sought in order to create a solid economic basis for their production. A long-range production program will be developed in collaboration with competent agencies.

Dr. Adolf Nichtenhauser, who was formerly on the staff of the National Tuberculosis Association and who has worked with educational cinematography for years, will be in charge of the section.

- Representatives from ten Southern states were present at the meeting of the Nursing Section of the Southern Branch of the American Public Health Association in St. Louis, Mo., November 10 and 11, 1941. Since the Southern Branch meets in connection with the Southern Medical Association, those in attendance at the Nursing Section have access to the scientific and educational meetings of both bodies.

Especially interesting was a panel discussion, "Where Should Emphasis Be Placed in the School Health Program?" presented by the Section, with E. G. McGavran, commissioner of health, St. Louis County Health Department, Clayton, Mo., as discussion leader.

The officers elected for the coming year are:

Chairman—Ella Mae Hott, Jefferson City, Mo.

Vice-chairman—O'Connor George, Jackson, Miss.

Secretary—Pearl Barclay, Montgomery, Ala.

- One of the scholarships in Health Education offered by the Massachusetts Institute of Technology through the Child Health Education Service of the National Tuberculosis Association has been awarded to Agnes Gerding, assistant in health education on the staff of

the Bronx Tuberculosis and Health Committee, according to a recent announcement by the Association.

- The United States Civil Service Commission announces that it has extended the closing date for receipt of applications for examinations for positions of health education consultant, associate, and assistant (\$3800, \$3200, and \$2600 a year) to January 12, 1942. This is an amendment of Announcement No. 155 of 1941, which gave December 11, 1941 as the closing date for filing applications. These positions have been created in the United States Public Health Service to assist state, county, and local health officials in coping with problems growing out of the nation's defense efforts. The examination announcement giving detailed requirements can be obtained at any first- or second-class post office or at the U. S. Civil Service Commission in Washington, D. C.

The United States Civil Service Commission is intensifying its recruitment efforts to secure physiotherapy aides for the government service. Examination announcements may be secured at any first- or second-class post office. Applications may be filed at any time at the U.S. Civil Service Commission in Washington, D.C.

As this issue goes to press the U. S. Civil Service Commission announces an examination for two grades of Public Health Nursing Consultant, (the Associate at \$3200 a year, the Assistant at \$2600 a year), for work in defense areas under the U. S. Public Health Service. Application forms may be obtained from the Secretary, Board of United States Civil Service Examiners, or any first- or second-class post office.

- The basis for membership on the Executive Committee of the Nursing Council on National Defense has been changed so that each voting agency is represented and each member is now considered as a representative of his agency. Following this policy, two new members have been added to the Executive Committee: Mary Beard, representing the American Red Cross, and Mrs. Mabel K. Staupers, representing the National Association of Colored Graduate Nurses.



# Official Directory of Public Health Nurses

*Listing those holding executive positions in the Federal Government, in national organizations, and in states and territories, officers of state organizations for public health nursing and public health nursing sections of state nurses' associations, and directors of public health nursing courses*

Information as of December 1, 1941, unless otherwise stated.

## National Organization for Public Health Nursing, Inc.

President, Grace Ross, City Department of Health, 3919 John R Street, Detroit, Mich.

General Director, Ruth Houlton, 1790 Broadway, New York, N. Y.

## American Red Cross, Nursing Service

*(All at American Red Cross, National Headquarters, Washington, D. C.)*

National Director, Mary Beard.

Assistant Director, Virginia M. Dunbar.

Assistant Director, Public Health Nursing, Disaster, and Associate Director of Nurse's Aides in Volunteer Special Services, Mrs. Elsbeth H. Vaughan.

Assistant Director, Gertrude Banfield, Enrollment.

Assistant Director, Red Cross Home Nursing, Olivia T. Peterson (temporary).

Assistant Director in charge of Health Education in the Nursing Service, Lona L. Trott.

Assistant Director assigned to Disaster Service, Ella Gimmestad.

Assistant to National Director, Annabelle Petersen, Enrollment.

Assistant to National Director, Marie Peterson, Enrollment.

Assistant to National Director, Mrs. Bertha M. Seering, Enrollment.

Assistant to National Director, Mrs. Thelma Bayard, Red Cross Home Nursing.

Assistant to National Director Anna C. Gring, Red Cross Home Nursing.

## Eastern Area

*(All to be addressed at American Red Cross, 615 North St. Asaph Street, Alexandria, Va.)*

Director, Lucy E. Massey.

Assistant Director, Virginia B. Elliman.

Assistants to the Director:

Mary E. Beam.

Winifred Bonham.

Eugenia Klinefelter.

Mary DeLaskey.

Mrs. Nellie P. Cuenco.

Esther Finley.

## Consultants:

Mrs. Thelma Bayard—Special Consultant in Home Nursing.

Bernice Cain—Indiana, Kentucky.

Frances Crouch—Massachusetts, Rhode Island, Vermont.

Mary A. Donnelly—Connecticut.

Mrs. Charlotte M. Heilman—New Jersey.

Mary McDevitt—Ohio, West Virginia.

Catherine Nardi—Maryland, Delaware, Eastern Pennsylvania.

F. Eleanor Strause—New York.

Florine Thomason—Virginia, North Carolina, South Carolina.

Iva Torrens—Maine, New Hampshire.

Emma Maurin—Louisiana, Mississippi, Tennessee.

Alice Dugger—Alabama, Florida, Georgia.

## Midwestern Area

*(All to be addressed at American Red Cross, 1709 Washington Avenue, St. Louis, Mo.)*

Director, Myrtis M. Coltharp.

Assistant Director, Rebecca Pond.

Assistant Director, Florence Spaulding.

Consultants:

Ann Magnussen—Minnesota, Nebraska, Iowa.

Ruth George—Illinois, Michigan, Wisconsin.

Edna Peterman—Arkansas, Kansas.

Virginia Stockard—Texas, New Mexico, Oklahoma.

Elizabeth McCoy—North Dakota, South Dakota, Montana, Wyoming, Colorado.

Catherine McDermott—Missouri.

Thora Wellman—Special.

## Pacific Area

*(All to be addressed at American Red Cross, Civic Auditorium, Larkin and Grove Streets, San Francisco, Calif.)*

Director, Gladys L. Badger.

Assistant Director, Edith Olson.

Consultants:

Mrs. Elizabeth Kulchar—Northern California.

Myrtle Campbell—Washington, Oregon, Idaho, Utah.

Katherine Forsythe—Southern California, Arizona, Nevada.

**National Association of Colored Graduate Nurses, Inc.**

President, Mrs. Frances F. Gaines, 649 East 50 Place, Chicago, Ill.

Executive Secretary, Mabel K. Staupers, 1790 Broadway, New York, N. Y.

**U. S. Department of the Interior  
Bureau of Indian Affairs**

Director of Nursing, Sallie Jeffries, Office of Indian Affairs, Department of the Interior, Washington, D. C.

Associate Public Health Nursing Consultant, Bertha Tiber, Office of Indian Affairs, Department of the Interior, Washington, D. C.

Field Nurse Supervisor, Mrs. Helen P. Olmstead, Care of Five Civilized Tribes Indian Agency, Muskogee, Okla.

Assistant Field Nurse Supervisor, Beulah Oldfield, Kiowa Indian Agency, Anadarko, Okla.

District Supervisory Nurses:

Mary E. McKay, 218 Federal Office Building, Minneapolis, Minn.

Gertrude F. Hosmer, Post Office Box 527, Albuquerque, N. Mex.

**Federal Security Agency**

Public Health Service; Public Health Nursing Section, Interstates Relations Division

Senior Public Health Nursing Consultant, Pearl McIver, U. S. Public Health Service, Washington, D. C.

Public Health Nursing Consultant—Mary J. Dunn, U. S. Public Health Service, Washington, D. C.

Associate Public Health Nursing Consultant, Mrs. Florence Callahan, U. S. Public Health Service, Washington, D. C.

Public Health Nursing Consultant, Donna Pearce, Johns Hopkins Hospital, Baltimore, Md.

Public Health Nursing Consultant, Anna Heisler, National Institute of Health, Bethesda, Md.

Public Health Nursing Consultant, Olive M. Whitlock, National Institute of Health, Bethesda, Md.

**District Public Health Nursing Consultants and Territories**

Rosalie Peterson, Sub-Treasury Building, 15 Pine Street, New York, N. Y.—Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont.

Bertha Allwardt, National Institute of Health, Bethesda, Md.—District of Columbia, Maryland, North Carolina, Virginia, West Virginia.

Henrietta Landau, Room 855, U. S. Custom House, 610 South Canal Street, Chicago, Ill.—Indiana, Illinois, Kentucky, Michigan, Ohio, Wisconsin.

Helen Bean, Room 1307, Pere Marquette Building, New Orleans, La.—Alabama, Florida, Georgia, Louisiana, Mississippi, New Mexico, South Carolina, Tennessee, Texas.

Mary D. Forbes, Room 112, Federal Office Building, San Francisco, Calif.—Alaska, California, Hawaii, Nevada, Oregon, Washington.

Vacant—Puerto Rico, Virgin Islands.

Lily Hagerman, 215 West Pershing Road, Kansas City, Mo.—Arkansas, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota.

F. Ruth Kahl, 64 Colorado Building, Denver, Col.—Arizona, Colorado, Idaho, Montana, Utah, Wyoming.

**U. S. Department of Labor**

Children's Bureau, Public Health Nursing Unit  
Director of Public Health Nursing, Naomi Deutsch, Children's Bureau, Department of Labor, Washington, D. C.

**Regional Public Health Nursing Consultants and Territories**

(To be addressed at Children's Bureau, Department of Labor, Washington, D. C.)

Hortense Hilbert—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New York, New Jersey, Pennsylvania, Delaware.

Ruth Heintzelman—District of Columbia, Maryland, Virginia, West Virginia, Puerto Rico, North Carolina, Kentucky, Ohio, Michigan, Illinois, Indiana, Wisconsin.

Jane Nicholson—Minnesota, North Dakota, South Dakota, Iowa, Nebraska, Missouri, Kansas, Arkansas, Oklahoma.

Ruth Cushman, Room 1048, 210 Baronne Street, New Orleans, La.—Alabama, Mississippi, Tennessee, Louisiana, Texas.

Mary B. Willeford, Room 1048, 210 Baronne Street, New Orleans, La.—Florida, Georgia, South Carolina, New Mexico.

Alice E. Brackett, Room 819, 821 Market Street, San Francisco, Calif.—Colorado, Wyoming, Montana, Arizona, Idaho, Utah, California, Nevada, Oregon, Washington, Territories of Alaska and Hawaii.

**U. S. Veterans' Administration**

Veterans' Administration Nursing Service—Superintendent of Nurses, Mrs. Mary A. Hickey, Veterans' Administration, Washington, D. C.

**ALABAMA**

Section on Public Health Nursing of State Nurses' Association—Chairman, Pearl Barclay, State Department of Public Health, Montgomery. Vice-chairman, Anna L. Sappington, Opelika. Secretary, Ada Fort, Opelika.

State Department of Public Health—Pearl Barclay, Associate Director of Public Health Nursing, Division of Hygiene and Public Health Nursing, Montgomery.

State Nurses' Association Paid Executive—Mrs. Walter B. Smith, 625 South Lawrence Street, Montgomery.

**ARIZONA**

**Section on Public Health Nursing of State Nurses' Association**—Chairman, Mrs. Cecelia Gillespie, 1539 Cherry Lynn Drive, Phoenix. Secretary, Gladys Irene Hill, 135 North Montezuma, Prescott.

**State Department of Health**—Jefferson I. Brown, Director, Division of Public Health Nursing, Phoenix.

**ARKANSAS**

**State Organization for Public Health Nursing**—President, Margaret S. Vaughan, Arkansas State Board of Health, Little Rock. Secretary, Marion Pool, Pulaski County Health Unit, Little Rock. Treasurer, Blanche Grasty, Fayetteville. Chairman Membership Committee, Mrs. Angie Faye Waldrum, City Hall Building, Little Rock.

**State Board of Health**—Margaret S. Vaughan, Supervisor of Public Health Nursing, Bureau of Local Health Service, Little Rock.

**State Nurses' Association Paid Executive**—Mrs. Mary Tolle Wright, 5404 T Street, Little Rock.

**CALIFORNIA**

**State Organization for Public Health Nursing**—President, Helen B. Reynolds, 1636 Bash Street, San Francisco. Secretary, Rosemary T. Kohes, 604 Mission Street, Room 802, San Francisco. Treasurer, Janet M. Roush, 726 North Tuxedo Street, Stockton. Chairman Membership Committee, Virginia Platt, 2340 Clay Street, San Francisco.

**State Department of Public Health**—Rena Haig, Chief, Public Health Nursing Service, 305 State Building, San Francisco.

**California Tuberculosis Association**—Irene E. Carlson, 45 Second Street, San Francisco.

**State Nurses' Association Paid Executive**—Harrlott L. P. Friend, Director at Headquarters, Room 309, 609 Sutter Street, San Francisco.

**COLORADO**

**Section on Public Health Nursing of State Nurses' Association**—Chairman, Louise Zetsche, 314 14 Street, Denver. Vice-chairman, Mrs. Ruth Huddleston, 1400 Cook, Denver. Secretary, Florence Sease, 243 East 19 Avenue, Denver.

**State Division of Health**—Mary Emberton, Director, Division of Public Nursing, Denver.

**Colorado Tuberculosis Association**—Mrs. L. Louise Gaghagen, 305 Barth Building, Denver.

**State Nurses' Association Paid Executive**—Irene Murchison, 621 Majestic Building, Denver.

**CONNECTICUT**

**Section on Public Health Nursing of State Nurses' Association**—Chairman, Marion M. Redmond, 570 Howard Avenue, New Haven. Vice-Chairman, Amelia M. Meyersieck, 40 Sanford Place, Bridgeport. Secretary, Dorothy Peckborn, 370 Hamilton Avenue, Norwich.

**State Department of Health**—Hazel V. Dudley, Director, Bureau of Public Health Nursing, State Office Building, Hartford.

**State Nurses' Association Paid Executive**—Margaret K. Stack, Room 512, 252 Asylum Street, Hartford.

**DELAWARE**

**Section on Public Health Nursing of State Nurses' Association**—Chairman, Mary Lenhoff, 200 West 34 Street, Wilmington. Vice-chairman, Mrs. Elizabeth Stone, 830 Kirkwood Street, Wilmington. Secretary, Lucille Wallis, Visiting Nurse Association, 911 Delaware Avenue, Wilmington.

**State Board of Health**—Alberta B. Wilson, Director of Public Health Nursing, Dover.

**Delaware Anti-Tuberculosis Association**—Mrs. Ethelwyn Hill Bacon, Sunnybrook Cottage, Preventorium, Marshallton.

**State Nurses' Association Paid Executive**—Mrs. Mildred A. Marshall, 914 Jefferson Street, Delaware Hospital School of Nursing, Wilmington.

**DISTRICT OF COLUMBIA**

**Section on Public Health Nursing of Graduate Nurses' Association of District of Columbia**—Chairman, Marie Daugherty, 900 Nineteenth Street, N. W. Vice-chairman and Secretary to be elected.

**District of Columbia Health Department**—Mrs. Josephine Prescott, Director, Bureau of Public Health Nursing, Washington.

**District Nurses' Association Paid Executive**—Edith M. Beattie, 1746 K Street, Northwest, Washington.

**FLORIDA**

**Section on Public Health Nursing of State Nurses' Association**—Chairman, Mrs. Audrey Gallion, 1215 Northeast 4 Street, Fort Lauderdale. Vice-chairman, Olive Seymour, Box 24, Deland. Secretary, Marguerita Libby, 1501 California Avenue, St. Cloud.

**State Department of Public Health**—Ruth Mettinger, Director, Bureau of Public Health Nursing, Jacksonville.

**State Nurses' Association Paid Executive**—Mrs. Phyllis R. Leonard, P. O. Box 1007, St. Augustine.

**GEORGIA**

**State Organization for Public Health Nursing**—President, Vera Mingleddorf, Griffin. Secretary, Mrs. Maud Fleming, Hall County Department of Health, Gainesville. Treasurer, Mrs. Palestine Coleman, State Department of Public Health, Atlanta. Chairman Membership Committee, Mrs. Eudelle Trawick, Sparta.

**State Department of Public Health**—Mrs. Abbie Roberts Weaver, Director, Division of Public Health Nursing, State Capitol, Atlanta.

**State Nurses' Association Paid Executive**—Dunrice Dickerson, 131 Forrest Avenue, Northeast, Atlanta.

**IDAHO**

**State Division of Public Health**—Mrs. Edith Carr, Director, Division of Public Health Nursing, Boise.

**Idaho Anti-Tuberculosis Association**—Elsie Withen (Acting Executive Secretary), 211 Capitol Securities Building, Boise.

**ILLINOIS**

**Section on Public Health Nursing of State Nurses' Association**—Chairman, Marguerite Boom, 1004 Main Street, Evanston. Vice-chairman, Hester Nicoles, 211 Richards Street, Joliet. Secretary, Mildred L. Ross, 1100 North LaSalle Street, Chicago.

**State Department of Public Health**—Maude Carson, Chief Division of Public Health Nursing, Springfield.

**State Nurses' Association Paid Executive**—Charlotte F. Landt, 8 South Michigan Avenue, Chicago.

**INDIANA**

**Section on Public Health Nursing of State Nurses' Association**—Chairman, Marie Winkler, 224 N. Meridian, Indianapolis. Vice-chairman, Rowena Harrison, 222 S. Holmes Avenue, Indianapolis. Secretary, Ruth Hall, District Health Department No. 1, Princeton.

**State Board of Health**—Eva MacDougall, Chief, Bureau of Public Health Nursing, Indianapolis.

**State Nurses' Association Paid Executive**—Helen Teal, 1125 Circle Tower Building, Indianapolis.

**IOWA**

**State Organization for Public Health Nursing**—President, Adah L. Hershey, Room 10, City Hall, Des Moines. Secretary, Hazel I. Roberts, Health District 8, Manchester. Treasurer, Mrs. Schuyler C. Johnson, Otho. Chairman Membership Committee, Marguerite Pfeffer, 610 Flynn Building, Des Moines.

**State Department of Health**—Marie Neuchaefer, Acting Director, Division of Public Health Nursing, Des Moines.  
**Iowa Tuberculosis Association**—Marguerite Pfeffer, 610 Flynn Building, Des Moines.

## KANSAS

**Section on Public Health Nursing of State Nurses' Association**—Chairman, Ruth McDonald, Division of Child Hygiene, State Board of Health, Topeka. Vice-chairman, Mary Alexander, Kansas Crippled Children Commission, 817 First National Bank Building, Wichita. Secretary, Manila Robbins, Box 83, Hays.  
**State Board of Health**—Mary E. McAuliffe, Supervisor, Public Health Nursing, Division of Child Hygiene, Capitol Building, Topeka.  
**Kansas Tuberculosis and Health Association**—Velma G. Long, 824 Kansas Avenue, Topeka.

## KENTUCKY

**State Organization for Public Health Nursing**—President, Lula B. McClain, 4445 South Sixth Street, Louisville. Secretary, Beatrice Daniels, Department of Health, Georgetown. Treasurer, Lucille Fentress, Department of Health, Greenville. Chairman Membership Committee, Clara Tapp, Department of Health, Smithland.  
**State Department of Health**—Margaret L. East, Director, Bureau of Public Health Nursing, Louisville.  
**Kentucky Tuberculosis Association**—Margaret L. East, 620 South Third Street, Louisville.  
**State Nurses' Association Paid Executive**—Mrs. Myrtle C. Applegate, 604 South Third Street, Louisville.

## LOUISIANA

**State Organization for Public Health Nursing**—President, Judith E. Wallin, 1624 Louisiana Avenue, New Orleans. Secretary, Celine McGinn, Alexandria. Treasurer, Grace Mizelle, Baton Rouge Parish Health Unit, Baton Rouge. Chairman Membership Committee, Frances Page, Ouachita Chapter, American Red Cross, Monroe.  
**State Department of Health**—Lorena Jane Murray, Acting Director, Division of Public Health Nursing, New Orleans.

## MAINE

**Section on Public Health Nursing of State Nurses' Association**—Chairman, Helen Dunn, State House, Augusta. Vice-chairman, Velma Pettiner, 178 Middle Street, Portland. Secretary, Mrs. Dorothy Bourgoign, Red Cross, Biddeford.  
**State Department of Health and Welfare**—Helen Dunn, Director, Division of Public Health Nursing, Augusta.  
**Maine Public Health Association**—Theresa R. Anderson, 15 East Crescent, Augusta.  
**State Nurses' Association Paid Executive**—Mrs. Alice S. Hawes, 54 Saunders Street, Portland.

## MARYLAND

**State Organization for Public Health Nursing**—President, Eleanor Immler, 31 South Calvert Street, Baltimore. Secretary, Charlotte von Briesen, 346 Rosebank Avenue, Baltimore. Treasurer, Irene Duffy, 1913 West Fayette Street, Baltimore. Chairman Membership Committee, Anna Persch, City Health Department, Baltimore.  
**State Department of Health**—Catherine Corley, Nurse Instructor, Division of Public Health Nursing, Baltimore.  
**State Nurses' Association Paid Executive**—Mrs. Blanche G. Powell, 1217 Cathedral Street, Baltimore.

## MASSACHUSETTS

**State Organization for Public Health Nursing**—President, Sophie C. Nelson, John Hancock Life Insurance Company, Boston. Secretary, Mrs. Ben Ross Schneider, 21 Winthrop Street, Winchester. Treasurer, Helen F. McCaffrey, 20 Commonwealth Avenue, Boston.

**State Department of Health**—Ethel G. Brooks, Chief Public Health Nursing Consultant, Boston.  
**State Nurses' Association Paid Executive**—Helene G. Lee, 420 Boylston Street, Boston.

## MICHIGAN

**State Organization for Public Health Nursing**—President, Anna L. Jenkins, Wayne University, Detroit. Secretary, Mrs. Paul Cotcher, Linden. Treasurer, Mildred Cardwell, Mason. Chairman Membership Committee, Ethel Mull, 576 Hollister Building, Lansing.  
**State Department of Health**—Helene Buker, Director, Bureau of Public Health Nursing, Lansing.  
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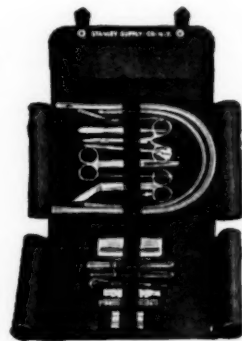
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# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## Your Nursing Defense Council

**P**UBLIC HEALTH NURSES are giving many valuable services in the present emergency and their efforts can be even more effective if dovetailed with the whole community plan for nursing.

Holiday messages from public health nurses this year were full of news about their defense activities. "I have been teaching Red Cross home nursing and expect to teach the nurse's aide course after Christmas." "I am taking a first-aid course." "What do you suggest? I've been asked to do eight different things in the first three days."

A married nurse with two children writes, "I am wondering whether I shall find myself back at work before this is over. If most of the young, unattached girls are called, those of us who are at home will probably have to take on the responsibility for local care."

Everywhere public health nurses express willingness to do their part in serving their community and their country in this crisis. But many of them are uncertain just where to begin—where they can make the most effective contribution.

Activities for nursing in defense programs are being coordinated through the nursing councils on defense in the states and local communities. Organization of state nursing councils has proceeded rapidly since the declaration of war, and a list of the secretaries and their addresses is published on page 111. These state nursing councils have been urged by the Nursing Council on National Defense to effect an organization tie-up with their

state defense councils so that there will be an integration of nursing in state and local plans for civilian defense.

The Office of Civilian Defense recommends that each state nursing council should have a representative on the state defense council. State nursing councils should consult with state chiefs of emergency medical service concerning ways in which information and assistance can be given to local nursing councils.

In some communities public health nurses have been active in organizing local councils; in others, where the integration of all nursing in the community is less developed, they are not even aware of the council's existence. Such a council has important tasks to perform—tasks which were outlined in Marian G. Randall's article "Your Part in Civilian Defense," in the January issue of this magazine.

If no nursing council on defense has been organized in your community, how can one be started? Assistance in establishing one can be secured from the secretary of your state nurses' association.

Coördination of nursing with other health and medical activities in the community is accomplished through nursing representation on the medical advisory council of the local defense council, as recommended by the Medical Division of the U. S. Office of Civilian Defense in its Bulletin No. 1, "Emergency Medical Service for Civilian Defense." (See October 1941 issue, page 575.) If no nurse representative has been appointed, the professional nursing group can use

their initiative to get in touch with the local chief of emergency medical service and urge the immediate appointment of a nurse.

There are many kinds of service which public health nurses are especially equipped to give. Some of the most important of these are outlined specifically in Miss Randall's article. Other activities are suggested in "Local Nursing Councils" on page 109. This outline of a council's functions emphasizes that public health nurses should be thoroughly informed regarding the emergency medical program and other activities relating to the protection of the civilian

population so that they may interpret them to the public with whom they are in constant contact. It also suggests that in community plans for care of patients evacuated from hospitals, the nursing care of patients in homes be assigned to organizations having public health nurses.

First of all, try to work through your local nursing council on defense—or if none exists, try to stimulate the organization of such a council. For only through a central group representative of all nursing interests can a coordinated program be drawn up and made effective.

P.P.

### "YES, I BELONG"

I LIKE being a member of the N.O.P.H.N. It gives you a sort of comforting feeling to know that you are not playing a lone hand in this big field of public health nursing, but that you can have the help, the advice, and the moral support of a large organization that has national representation and standing.

I have turned to the National Organization many times during these last few years for information and help. My president wanted to know how many private agencies in the country were receiving tax funds at the present time and how they were allocated. The N.O.P.H.N. sent me this information.

We were anxious to have one of our orthopedic nurses complete the longer course in physical therapy so that she might be adequately prepared for her work in the association. Through the National a scholarship was secured for her.

We wanted to know what was the

accepted technique for giving routine care to the newborn baby. The N.O.P.H.N. *Manual of Public Health Nursing* told us.

I wanted some reprints on industrial nursing to help me think through possible plans for such a project in our association. The National sent them to me free of charge.

We wanted to start a volunteer program. The N.O.P.H.N. lent its consultant on lay participation to advise us in making plans.

We felt the need of making a study of some of our administrative procedures. The National gave us advice and suggestions through correspondence, personal interview, and study.

So it is with a feeling of thankfulness and pride that I can look anyone in the face in discussing my profession and say simply—"Yes, I belong!"

DOROTHY J. CARTER, R.N.

General Director, Community Health Association, Boston, Massachusetts





## Public Health Nurse in a Defense Area

Colorful excerpts from letters of public health nurses assigned to defense areas tell the story of what they are doing on their new jobs.\*

**I**NCREASED health problems in so-called critical areas of extra-cantonment zones and around large defense industries have necessitated an expansion of public health services to meet these new needs. Through an appropriation by Congress to the U. S. Public Health Service, additional public health nurses—as well as other public health personnel—have been secured, given a special orientation program, and placed in these defense areas.

After the three or four weeks' preliminary orientation period at Bethesda, Maryland, the public health nurses employed for defense work are assigned to the various states and territories in accordance with requests from the state health officers, together with a consideration of the urgency of the situation

and the needs of the defense areas concerned. However, no one is assigned to a state, unless there is first a specific request from the state health commissioner for additional nursing personnel. At the present time, there are still many unfilled vacancies in the defense areas.

After assignment to an area, despite the fact that the nurse receives her pay checks from the Federal Government she is no longer considered as working under the direct supervision of the U. S. Public Health Service. On the contrary, from the moment she arrives in a state a nurse is to all intents and purposes a member of the state and (or) local unit in whatever defense area she may have been assigned. This specific assignment is made by the state itself after the nurse

\*Prepared by Florence Callahan, Associate Public Health Nursing Consultant, U. S. Public Health Service, Washington, D.C.

NOTE: In the spot map the round dots represent the public health nurses and the squares, the supervisors.

**WHERE THE 111\* NURSES EMPLOYED FOR HEALTH WORK IN DEFENSE AREAS  
HAD THEIR PUBLIC HEALTH PREPARATION**

School	Total	Classification of defense nurses			
		Junior public health nurse	Public health nurse	Assistant public health nursing consultant	Associate public health nursing consultant
<b>Total</b>	<b>111</b>	<b>3</b>	<b>94</b>	<b>9</b>	<b>5</b>
Columbia University	18	—	10	5	3
Simmons College	15	1	14	—	—
University of Minnesota	14	1	12	1	—
Western Reserve University	10	—	8	1	1
University of Pennsylvania	9	1	8	—	—
University of Michigan	7	—	5	1	1
Ohio University	6	—	6	—	—
George Peabody College for Teachers	6	—	6	—	—
College of William and Mary	5	—	5	—	—
Syracuse University	4	—	4	—	—
New York University	4	—	4	—	—
Catholic University of America	3	—	3	—	—
Medical College of Virginia	2	—	2	—	—
University of Oregon	2	—	1	1	—
University of Washington	2	—	2	—	—
Vanderbilt University	2	—	2	—	—
St. Louis University	1	—	1	—	—
Wayne University	1	—	1	—	—

has reported to the health department for duty and has been inducted into the service.

The questions most frequently asked regarding the nurses who have been assigned to the defense areas are:

1. How many nurses are there and where are they located?
2. What do they do?

At the present time 111 public health nurses have been assigned to field duty in the defense areas.\* This includes 3 junior public health nurses, 94 full-grade public health nurses, 9 assistant public health nursing consultants, and 5 associate public health nursing consultants. They are scattered throughout the entire country, including two who have been assigned to Hawaii and two to Alaska. Outside of Hawaii and Alaska the assignments have been entirely in the states. The assignment of the nursing personnel follows closely the concentration of defense activities along the eastern and

southern portions of the United States as shown by the spot map. The institutions in which these 111 nurses received their public health preparation are shown in the chart above.

Naturally, as would be expected with a group of over a hundred individuals, it is impossible to meet each nurse's wish for an appointment to a specific area. Assignments must be made on the basis of defense needs. Thus we may find nurses who, desiring to go to the northern part of the country, are assigned to the south; and some wishing to go south are sent to the north. As one young nurse recently wrote.

Everything is crowded! Isn't it funny that one who wanted the wide open rural areas of the west got into a crowded seaboard area of the east? However, I do feel that there is a good reason for everything, so I will probably like it here and will try to do a good job.

To do a good job! That is the philosophy which typifies the thinking of each one of the "defense" public health nurses. I have seen this thought expressed over and over again in the letters which have

\*This paper was read in October 1941. At the present time there are 150 nurses.

been sent back to the directors of the orientation program and can truthfully say that these nurses have risen to the occasion, have placed their personal wishes in the background, and are making a worth-while contribution in whatever area it may have been their fortune to be placed.

I have in mind another nurse who felt that the United States consisted of but two places—Texas and the rest of the country, with Texas of course being the really important part. It happened that this nurse was not assigned to Texas, as naturally she wanted to be, but to one of the eastern states. I do not doubt but that she was quite unhappy during the first few weeks of her new assignment. However, at the present time she is making a wonderful adjustment; in fact, she believes that there are now three places in this country—Texas, Maryland, and the rest of the United States. Her letters are extremely interesting and show what can be done when there is a will. She says:

Your comments on my adjustments make me very happy. Every effort has been made on my part to adjust and represent the U. S. Public Health Service and my county in a satisfactory manner.

The work is stimulating. I find myself rising every morning with a new zest for adventure—poliomyelitis. Rocky Mountain spotted fever, typhoid fever, poor sanitation, one-room cabins in the backwoods, a chance for teaching nursing care because of the shortage of hospital beds. Challenge! Everything I want—with the Red Cross expense account at my disposal if my ingenuity fails.

One of the biggest things my change in assignment has done for me is to enable me to realize that there are 47 other states, each of which has some very pleasant assets. It is rather a surprise, inasmuch as I could see nothing but Texas during my entire lifetime.

Of course some credit for the ease with which many of the personnel have adjusted to local conditions must be given to the directors of the orientation program. Knowing something of the problems in many of the areas, they tried

to incorporate a philosophy of preparedness into the thinking of the nurses. That they succeeded with some of the group at least may be seen from the following excerpt:

Curiously, I found the orientation course of distinct advantage. I can speak of program with a fair degree of intelligence. I have a better idea of "shoe-leather" epidemiology in venereal disease work and I was able to foresee some of the disadvantages of defense areas so that I wasn't surprised. I have now met most of the adverse conditions described to me before I left Washington. It was rather fun to check them off as I met them. The first week I lived in a cubby hole and left most of my baggage in the car.

#### WHAT THE NURSES DO

But what are some of the duties and experiences, and the environmental surroundings of the public health nurses in the various defense areas? A nurse when assigned to an area fits into whatever program is already being carried on there, in the same way as would a new staff nurse employed directly by the local health unit.

Interesting letters have been received from nurses who have been assigned to county health units which are in the process of being organized near several of the larger cantonment areas. They show clearly what some of the programs are in such areas and what a challenge they provide for the nurses.

Prior to 1940, Smithville was a town of one hundred or less persons. I will cite you a few of the examples of growth and you can judge from these what other expansion has been necessary:

The postoffice business increased 738 percent. Movies increased from one to three, two of which have vaudeville of a poor sort. Restaurants increased from 5 to 37. Cleaning establishments increased from 1 to 7. Also many playhouses, such as skating rinks, pool-halls, and other types of commercial recreation, were established.

After three weeks of the trial-and-error method the sanitarian and I secured some unpainted, hand-made tables. We collected orange crates, tomato boxes, and apple boxes

to use as filing cabinets and storage space. We are still without a contingent fund so we have no telephone, janitor service, or clerk. The work has been most interesting and challenging. We have been welcomed and assisted in every way possible. The people have very little conception of the work, and each day, problems requiring a definition of policy and duty present themselves.

Of course you know that housing is the outstanding need. The townspeople have tried to meet the need by opening their homes. There has been and still is a huge building program in progress.

My chief interest now is maternal and infant hygiene. I have a list of over 75 pregnant women and I have been trying to organize them into groups but so far have been unsuccessful. The infant diarrhea problem is also one of paramount importance. Most of the cases of this infection are among the Mexican families. I am studying Spanish but do not know enough yet for group instruction. I have one group organized which I teach through an interpreter.

I am so thankful that there has been no outbreak of any communicable disease. I feel that if this can be avoided until I am better oriented I will be of more service. Of course we are trying to watch for and prevent any epidemics but the immunization rates are low and epidemics must be considered a possibility. We have a new venereal disease clinic and I must report on the progress of this phase of the work later.

This to me is a strange country. It is so flat and so huge. The sky is so close to the earth. I like all of it. I do not suffer from the heat and I would vote it the best place I ever lived if it were not for the pestiferous "varmints," which make life very tiresome at times.

I wish to thank you for your help while I was in the training center. Both the sanitarian and I refer to the material given us at frequent intervals.

Another excerpt is taken from a letter of one of the western nurses:

As you know, this is the first organized county unit in the state, and both Miss Black and I feel that this is a wonderful opportunity to learn. It is a grand experience. If you can imagine explaining our services to people who have never seen or heard of a public health nurse! Some think that we are going to take the place of a doctor and are thrilled that finally they can have some help.

There isn't a doctor for miles and miles here. In the eastern part of the county they

must go 22 miles; in the western, 45 miles; in the northern and southern part there is no physician for 100 miles. Dr. Smith is the only one here. He is also the town mayor, Lions Club president, "inventor," mechanic, ambulance driver, philanthropist, and druggist.

After I've seen the people I try to find some place where I can come to get my calls, if there are any. In one town the postmaster is more than willing to have people call and leave their names and addresses. In another, the only place we could use would be the grocery store—and there are two. There seems to be a feud between them. They are next door to each other and I am going to use both places.

#### PROBLEMS ARE DIFFERENT

However, not all new health units require the same type of organization work. For instance the nurse who writes the following letter certainly has a much different problem:

This building of a new unit is interesting business. It's really thrilling to make history, especially since I've only worked in a highly organized and smoothly running unit. The situation here is not a typical one either. In this county there are two cities of about equal size, which are sworn enemies. Each has its own type of health work, and our job—no small one—is to combine them and the rest of the county into just one big happy family. We are really starting at the bottom for we didn't even have a headquarters when I arrived.

I didn't think when talking about preliminary surveys in Washington that they could be so very fascinating. I only hope that I am liked as well as I like these people—and my job.

Of course not everyone has had these tremendously interesting and challenging experiences, for many who were assigned to well organized health departments found that their bit consisted in being a cog in an already smoothly running, although overworked, machine. The fact that these routine duties are just as important as the more stimulating challenge of organizing a new service is being recognized by most of the public health nurses who have found themselves in this type of defense area. They know that not all of us can be pioneers; that some of us must remain content with the

knowledge that the routine things we are doing are as necessary to the national defense program as are the more dramatic duties. Letters from public health nurses who have been assigned to the "routine" type of area show that the nurses themselves feel this way. In the words of one nurse:

This is one letter that is not going to be full of complaints for there is nothing to complain about.

Another remarks:

The group that is working here—a medical director, sanitarian, two nurses, and a clerk—are very congenial and enthusiastic. However, they have been handicapped by insufficient personnel—only one nurse until May—for a county of 38,000 and a rapidly increasing population. I have felt green because of the clinics and the treatments given by nurses, to which I have not been accustomed. The personnel are very kind about helping me to catch on. I have been awed and scared at some of the bad rural roads over which we have driven.

Here, too, is an interesting note from a nurse whose location is rather unusual:

My work is regular home visiting in a generalized program, organizing mothers' clubs, holding midwife classes, et cetera. Since my district is composed chiefly of islands, transportation is a problem in certain areas. Several of the islands can be reached only by boats and then there is no means of transportation. Hence, it is necessary in these places for the nurse to have the people meet her at central points for group and individual conferences on various phases of health education.

The problems of housing and sanitation are two of the major difficulties which are confronted by many of the public health nursing personnel. This letter from a nurse who was assigned to one of the military defense areas is typical and shows what is happening in hundreds of similar places:

The housewives found that rooms which were rented for \$8 a month before the construction work of the camp began were worth four and five times as much to the laborers who flocked into town seeking employment. When the wives of the service men came here to make

their homes, rent was so high that they were compelled to live in trailers or small shacks, or return to their home towns. During the past two months a number of FHA houses have been built and private owners have enlarged dwellings to increase the number of living quarters. But there has been little change in rental prices.

There are numerous sanitary problems. Fifteen miles from here one of the sanitary engineers found that the stock drank from the reservoir which supplies the town and surrounding farms with drinking water. The water supply is turned off at night to prevent farmers from watering their stock—a practice which would drain the reservoir to the extent that the townspeople would have no water to drink in the morning. I am learning to eat mustard greens, okra, and corn bread.

Another nurse from the west shows the same problem when she says:

The water supply is inadequate. The influx of people has made it necessary to have so-called watering days on which people may use water without restriction.

Housing is the problem that I have been confronted with personally. Rents are very high and in many instances it is impossible to find living quarters. Carpenters are living in unfinished buildings and many spend their nights on the courthouse lawn.

Of the nursing personnel, only one has been privileged to establish her living quarters on a military reservation itself. This nurse was assigned to the extra-cantonment area because of the high incidence of venereal disease among the troops and her responsibility was primarily to develop a control program as a joint undertaking of the Army officials and the local health department. Her story is different from that contained in most of the letters:

The Fort is quite an ideal place to live in although it is practically isolated by desert and mountains. It contains all kinds of recreational facilities intended for the soldiers, but enjoyed by all, such as tennis courts, swimming pools, bowling alleys, theaters, and a library—besides other conveniences such as grocery stores, cleaners, shoeshop, garage, and a filling station. By being allowed to live on the reservation, we can buy food at a great saving. For example, bread can be had for



two cents a loaf whereas the regular price is 15 cents. Gasoline is 15 cents a gallon here while outside the post it is 23 cents.

I am sure that the other public health nursing personnel will be delighted to know that one of their group at least has no housing or food-price problems!

It is also interesting to note how very quickly the personnel get the feeling of belonging to the local unit. For instance, after describing the very bad condition of the water supply and the great need for a sewage disposal plant, one nurse says:

A sewage project for the city is waiting approval. Do you suppose that some of that 150 million dollars could be used for Whiteville?

The enthusiasm of the nurses is sometimes marvelous. You would never imagine that the thermometer was probably 100 degrees or over when this was written:

I found the work in my district about the same as usual public health nursing. We have a great deal of maternity work and this month will see the opening of the first maternity clinics. I must tell you about my health center (I am really proud of it) at Leadville. I went to some of the citizens there and urged the opening of a health center. They caught on to the idea, borrowed a building, and went at it while I stood by and cheered. The center was opened with a well child conference, which was followed two days later by the first of weekly venereal disease clinics. We will have two maternity clinics a month and I plan to use this as a center for teaching midwives and for a mothers club.

This paper would be incomplete without a few of the interesting items about the two nurses who were assigned to the territory of Hawaii. Of course they were immensely thrilled at the prospect of going, had a wonderful trip, and were given a royal welcome when they arrived in Honolulu. This excerpt is quoted from a letter written by one of them:

Dr. — gave us a Spanish welcome—a kiss on each cheek, which I am sure no other public

health nurse has received from the director of any state health department!

Some of the problems that they are already encountering are quite similar to ours here on the mainland:

Hospitalization is getting to be another acute problem especially for obstetrical cases since none of the Honolulu physicians will attend home deliveries and there just aren't enough hospital beds. There is some talk of setting up beds in the receiving rooms of the hospitals to deliver patients and then sending them back home as soon as they have recovered from the anesthetic. The public health nurse will have another problem when this is done and I wonder what will happen to our low maternal mortality rate of 2.3.

I have the famous Waikiki Beach area and have some of the slum areas in which there are many Hawaiian, Portuguese, Japanese, Chinese, and Korean families. I haven't mastered the pidgin English which is the spoken language of many of these people. The people are very interesting and have their own particular racial customs. No two homes are alike.

Here, too, just as in other defense areas, housing constitutes a major problem. Rents are exorbitantly high—with one-room studio apartments for two costing \$30 to \$50 a week—and food costs are almost prohibitive. However, she concludes on a very optimistic note:

I think I will enjoy working here. Racial prejudice just doesn't exist, for the Chinese and Japanese nurses work side by side in complete harmony. I love to hear them talk, as many of them have peculiar accents.

I could continue indefinitely with similar descriptions of other nurses and other areas! However, these would but further illustrate this important point: There is a job to be done. The public health nurse is there to help do it. And she is trying her best to do it well.

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Presented before the Public Health Nursing Session, Annual Meeting, American Public Health Association, Atlantic City, New Jersey, October 16, 1941.

NOTE: Identifying information concerning names of persons and places in the various quotations has been deleted and appropriate substitutions made.

# Nurse Placement Service



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

## PLACEMENTS

- \*Emma Sater, Director of Nurses, St. Joseph's Organization for Public Health Nursing, St. Joseph, Mo.
- \*Helen Fisk, Field and Clinic Director, Margaret Hague Maternity Hospital, Jersey City, N.J.
- \*Marion A. Curtis, Supervisor of Public Health Nurses, Yellowstone County, State Department of Health, Helena, Mont.
- \*Mary W. Zurowska, Public Health Nursing Supervisor, Department of Public Health, Bloomington, Ill.
- \*Alma E. Foerster, Area Health Administrative Officer, National Youth Administration for Illinois, Mount Vernon, Ill.
- \*Blanche Banks, Resident Nurse, Lake Forest Academy, Lake Forest, Ill. (temporary).
- Esther Fairchild, Resident Nurse, Lake Forest Academy, Lake Forest, Ill.
- Mrs. Virginia Bond Olson, School Nurse, Ranchito School District, Pico, Calif.
- \*Zimrode Eaton, School Nurse, Amarillo Public Schools, Amarillo, Tex.
- Mrs. Betty Rae Taylor, Industrial Nurse, United Specialties, Chicago, Ill.
- Lorraine Duggan, Industrial Nurse, The Hub, Chicago, Ill.
- Marjorie E. Little, Industrial Nurse, Container Corporation, Chicago, Ill.
- E. Loretta Anderson, Field Nurse, Community Service Society, New York, N.Y.
- \*Charlotte Dayrell, Staff Nurse, The Visiting Nurse Association, Los Angeles, Calif.
- \*Lucille K. Poseley, Staff Nurse, Visiting Nurses of San Diego, Inc., San Diego, Calif.

## ASSISTED PLACEMENTS

- \*Sophia A. Jarc, Consultant Public Health Nurse (Educational Supervision), State Department of Health, Albany, N.Y.
- \*Mrs. Bessie Krupsaw Littman, Supervisor, San Luis Obispo County Department of Health, San Luis Obispo, Calif.

Eva Clark, Staff Nurse, Public Health Nursing Association, Charleston, W.Va.

1931—1941

Ten years of activity for nurses, by nurses, in the interest of good nursing service! The completion of a decade of serving nurses vocationally was celebrated by birthday ceremonies in each of the five state nurses' associations that together comprise the Midwest Division of the American Nurses' Association—which founded and continues to sponsor as its sole project, this truly professional service.

In June at Marquette, Michigan nurses jointly honored Nurse Placement Service and Grace Ross—a home-town girl who made good—at a beautiful luncheon. Miss Ross served for many years as a member of N.P.S. and the Midwest Board. In October, Iowa held a candle-lighting ceremony—ten nurses, ten candles, and a huge birthday cake—with a patriotic feature called the Defenders of Old Glory. Indiana had a birthday tea in Indianapolis with a long receiving line and more than 500 nurses attending. Illinois had a cake-cutting ceremony at its large banquet with Lyda W. Anderson presiding, while the soldiers' chorus from Rantoul Field (in uniform) sang "Happy Birthday." A morning session on vocational guidance was also held under the auspices of the Midwest Division, with Alice E. Dalbey presiding. Wisconsin featured a cake and trimmings at a luncheon of the State League of Nursing Education.

N.P.S. came into existence as a "depression baby," an outcome of the work of the Committee on Distribution of Nursing Service of the American Nurses' Association. It was then that nurses so

(Continued on page 125)

\*The N.O.P.H.N. files show that this nurse is a 1941 member.

# Oklahoma Develops Lay Committees

By ODESSA WINTERS, R.N.

Lay committees form the backbone of a new and rapidly growing official health program in a five-county area.

**L**AY ORGANIZATION is responsible for the integration of health education into community life throughout a five-county area in Eastern Oklahoma. The success of the generalized public health program—which includes delivery nursing service in one county—has been brought about by an educational program carried on through organized lay groups.

The Coöperative Health Unit, District No. 1, of the Oklahoma State Health Department consists of a five-county area, including Adair, Cherokee, Delaware, Mayes, and Sequoyah counties, representing 3388 square miles. The population of 100,000 is approximately two-thirds white and one-third Indian, with a few Negroes. The public health program was started in April 1936. The professional staff consists of a medical director, an obstetrical consultant, a pediatric consultant, a director of venereal disease control, two sanitarians, thirteen public health nurses, a medical social worker, a supervisor and an assistant supervisor of public health nursing, and a part-time laboratory technician. A branch laboratory serves the eastern part of the state.

The first organized lay efforts began in the spring of 1940 in Delaware County as a result of an institute on lay participation conducted by a member of the staff of the National Organization for Public Health Nursing. A group of representative citizens met for the purpose of electing officers and committee members in order to assist the health depart-

ment personnel to develop a generalized public health program as an integral part of the community life—a program which would take its place along with the churches, schools, and social agencies, as a permanent institution.

This beginning served as a stimulus to other areas, and a county lay advisory committee was organized in adjoining Mayes County. A third and fourth followed in Cherokee and Adair counties. Each group reviewed, revised, and adopted a constitution and bylaws recommended by the National Organization for Public Health Nursing. These covered the needs and governed the activities of the various groups, and at the same time set up the following general objectives of the committees:

1. To know the health department by becoming informed in regard to the services it renders and those available to the public.
2. To learn the needs of the community and how they are met.
3. To assist the health department with a continuous educational campaign in regard to sanitation, control of communicable diseases including tuberculosis, and programs for maternal health, child health,\* and social hygiene.
4. To aid the health department in maintaining high standards of service.
5. To promote a coöperative working relationship among all public health agencies.

## COMMITTEES ARE ACTIVE AND BUSY

The membership is representative and is open to those interested in some phase of public health service who express a willingness to assist in the program. Persons are elected to active membership by a majority of members present

\*See "A County Health Unit with Proper Functioning Maternal and Child Health Program," by Isadore Dyer, *American Journal of Public Health*, May 1941, p. 471.

and are dropped by the same procedure when they cease to function or when their terms expire. This method assures an active committee at all times.

The permanent committees are: publicity committee, program committee, nominating committee, and educational committee. Special committees are appointed when the need arises, to carry on some specific phase of the program. It was suggested that these committees make a special study of available statistics and laboratory reports to determine the problems now existing. This study resulted in a community survey which revealed many unrecognized health hazards. For example, stagnant pools of water and old tin cans were known breeding places for the anopheles mosquito, a source of malaria infection. Methods of disposal of garbage and excreta were unsanitary. No ordinance existed for the control of food handlers or milk supplies. The Lay Service Education Committee has outlined a program through which, with coördinated community efforts, these health hazards will be eliminated.

Health education has spread into the most remote rural areas. Existing organizations are utilized for education through group thinking and group teaching: the public schools, teachers' colleges, farm women's clubs, civic organizations, child and public welfare departments, the tuberculosis association, the ministerial alliance, and county officials. The press, the radio, films, and literature, serve as educational media.

#### LAY GROUPS GET RESULTS

Accomplishments of the lay groups include the establishment and upkeep of loan closets by lay workers, the securing

of office buildings to house the health department personnel, the installation of permanent heating plants in such buildings, and the landscaping of health department grounds. The groups have already suggested a district organization for lay workers which would become a part of the Oklahoma State Public Health Association. Recently at a district meeting, a lay person made an outstanding talk to the professional group on lay participation.

In addition to the general educational program, special projects have been sponsored by lay committees and schools which plan county-wide health programs. Talks have been made on the control of tuberculosis and syphilis. The committees sponsored a district-wide May Day program, presenting material on many phases of health, including family nutrition with emphasis on the importance of vitamins, minerals, and other food elements in normal growth and development. Posters, pageants, skits, playlets, and talks over local radio stations were used in this project.

The development of the whole health program has been gratifying. We are still pioneering in public health in Oklahoma. But in its early history health workers were looked upon as imposters prying into the personal lives of the people. Today, through the coördinated efforts of all, the picture has changed. Both young and old in all walks of life come to the health centers, requesting in professional terms the various types of service. The public health nurse in gray uniform is their friend and is welcomed. Through the effort and support of the lay committees the public health service has found a place in the hearts of the people.

# A Staff Studies Its Records

By GRACE MUSSELMAN, R.N.

A STAFF EXPERIMENT carried out by the Infant Welfare Society of Chicago shows how the problems frequently encountered in writing records can be solved through staff participation. The program was developed through the following steps.

Samples of the records of the Society which had been written by the nurses were examined and analyzed by the staff. This study of agency records provided a basis for further consideration of what constitutes an adequate record. It gave an index as to the kind and number of recommendations made by the nurses to patients and families in the health education program, and showed where emphasis in teaching was placed. It revealed repetition and some gaps in the content of the records.

After this analysis the staff nurses and supervisors selected references from public health literature and from the field of social case work to broaden their knowledge of record writing. News reporting was studied for methods which might be applicable to nursing records. The aims were to increase the participants' knowledge of record-writing and to set up criteria for adequate recording.

Reports from the selected books and magazines were given by staff members in round-table groups of about ten persons each until the entire staff had taken part in the discussions. Informal, free discussion followed the reports. Nursing supervisors and special supervisors as well as the staff nurses attended these conferences. The superintendent of the agency had previously participated in the selection of study material.

The reports from the literature emphasized the importance of records as an

inseparable part of public health work. The main functions of these records are to provide adequate and continuous treatment to the family, to interpret the work of the agency to the community, to promote the nurse's professional growth, and to provide a basis for supervision. The emphasis throughout was on records as a part of public health work, not as ends in themselves.

After considering reasons *why* it is desirable to write good records, the nurses studied *how* to write them. The desirable attributes of a good case record were discussed in detail. Attributes considered important were accuracy, objectivity, brevity, conciseness, completeness, legibility, clarity, uniformity, and up-to-dateness. Ease of reference was stressed. Some of these characteristics, such as objectivity and brevity, may seem contradictory; objectivity implies the use of objective examples rather than briefer subjective statements. It is therefore important to make a careful judgment regarding what is most important and to sacrifice what is less essential.

The group agreed that records should be kept within a reasonable length in order to avoid bulkiness of records and excessive time in writing them.

## STUDY APPLIED TO AGENCY RECORDS

The principles drawn out of this study of record-writing in general were then applied to the agency records in particular. Several suggested ways of making a record more usable—such as making summaries, having a definite place in the record for certain types of information, and using colored sheets for specific purposes—were found to be already in use.



Suggestions for changes in record writing emerged from the discussion. The value of logical paragraphing of the narrative was brought out. The news-writing device of putting the most important item at the beginning of the paragraph was utilized. One example from records illustrated this point. The nurse had made a visit to find out whether a patient with active tuberculosis had been removed from the home and to persuade the contacts to be examined. In writing up the visit, however, the nurse devoted much space to descriptive and comparatively unimportant recording. At the very end of the write-up she said that the tuberculous woman had been hospitalized.

Another change was suggested in the interest of clarity. Each recorded finding of the nurse is to be followed with the instructions which she gave instead of recording all findings followed by all instructions, as had been done previously.

A third change to facilitate quick reference to the record was the introduction of marginal notes, which were restricted to three headings: diagnosis, family history, and family attitudes. They proved to be useful in directing attention to specific information.

Besides these actual changes in record-keeping, other benefits resulted. The nurses expressed more interest in writing good records, and made a real effort to improve this phase of their work. Since supervisors and staff had shared in a cooperative learning process, all shared in the feeling of accomplishment which

resulted from changes that were made.

The study also provided criteria for teaching record-writing to new nurses on the staff. The same criteria have provided a basis for the nurses' evaluation of their own records, and less directly, of their own work. It has also proved an aid to supervision. The old question asked by staff members, "How are my records?" can now be answered by comparing the characteristics of a good record as set up by the staff with the records in question. These criteria provide a standard, without hampering an individual's own style in expressing herself.

Since the qualities desirable for good recording, such as accuracy, objectivity, and discrimination in selection of material, are equally necessary in other aspects of the work, it is believed that some transfer will occur from this experience to the nurse's work as a whole.

From the study, too, came a realization that record writing, like all other phases of public health work, has changed and evolved through the years and that no methods can be considered final.

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Satisfaction in one's work and security in one's status are the positive aspects of mental health. It is the defection of these that engenders blame, creates scapegoats, and demoralizes a people into grasping for the hollow half loaves of the dictator.

—George S. Stevenson, M.D., Medical Director, National Committee for Mental Hygiene

# Community Nursing---FSA Style

By MATILDA ANN WADE, R.N.

Farm Security Administration projects open a new way of life for thousands of farm families who now have a chance to earn a living and provide for their families

THE NURSE drove out to see the Browns. She wanted to tell them about the typhoid inoculation clinic. But Farmer Brown had heard about the clinic and his answer was ready.

"No, Ma'am," he said, "we won't go there next week—or the one after that, either. I don't take stock in such doings and I don't want anybody in my yard that gives any of that stuff. They might bring a lot of germs in."

To this Missouri farmer, inoculations were nothing but a lot of foolishness, and he wanted none of them. Hundreds of other farm families who moved to homestead projects managed by the Farm Security Administration felt the same way about these newfangled ideas.

Coping with such prejudices is all in the day's work for FSA nurses. In these closely knit rural communities a new chapter is being written in American nursing annals. The chapter is new because here the nursing service is part of a fully rounded program of rehabilitation—physical, economic, social, educational—and, yes, spiritual. As one nurse said, "Usually in working with low-income families, you feel as though you're beating your fists against a stone wall, a stone wall built out of poverty and poor diets and insanitary living conditions. Here it's different. The people have financial aid to get the things they need, and they have educational guidance necessary to make a living."

FSA homestead projects were set up to provide good homes and good land for families who were stranded on worn-out farms or cutover forest areas and could not make a go of it. Seldom able to get enough cash from their crops to make ends meet, most of these families had mortgaged what they owned, and lost everything when agricultural depression set in.

For many of them poverty finally had shut the door to the doctor's office, to schools, and to community activities. A graphic picture of their plight was painted by one project manager when he reported that "some families had to have clothing before they could appear in public." It is little wonder that ignorance and superstition followed many of these people from their old homes to their new. Little wonder that a mother who had just given birth to her seventh son wanted to know if her "vocal chords could be cut" so she wouldn't have any more children!

## FARM FAMILIES GET NEW START

But a new way of life was in store for nearly 15,000 families who took up homesteads on the 148 FSA projects scattered throughout the United States. Once these people were settled on good land, the Farm Security Administration was able to help them with loans for equipment, plus guidance in sound methods of farming and home management—the same kind of assistance that



Smiles greet the community nurse as she visits a family on the project

has aided nearly a million other farm families in the country to get a new start.

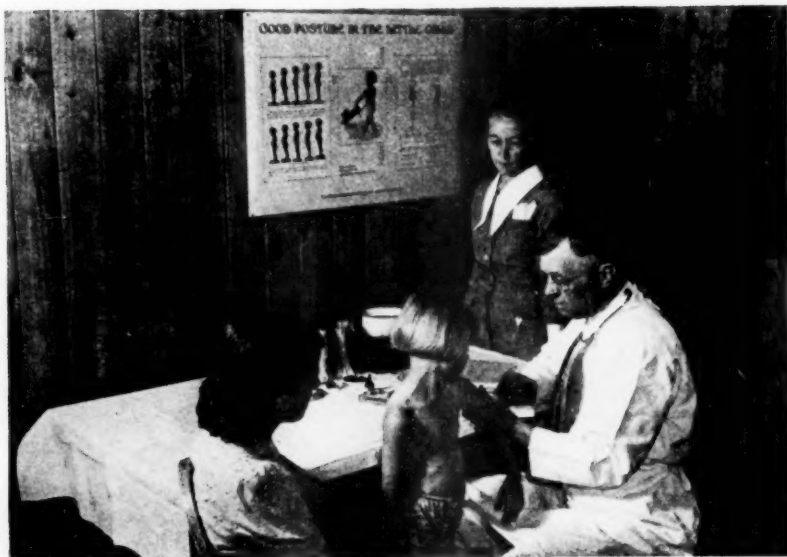
On homestead projects, groups of from 50 to 200 families lived as neighbors and worked together. They had their schools, their church services, their business meetings, and socials. Before long, farm families in the surrounding areas were drawn into the community life of the projects. Children outside the projects attended school with the homesteaders' children. Their parents joined the "doings" at the community buildings, enrolled in evening adult education classes, and attended an occasional lecture or movie.

Although a stimulant to neighborliness, the close contacts of community life also provided an assembly ground for communicable illnesses. But foresighted health measures had been taken when the projects were started. The modest, well built homes were screened against flies or malaria-carrying mosquitoes. A sanitary privy and safe

water supplies were provided on every farm. Gradually, community nursing services have been set up and are now in operation on 45 projects.

Room for a health center was usually provided in the community building, or a new structure was erected. In a few cases, the homesteaders got together for an old-fashioned barn-raising and built their own. A health center is now being put up by residents at Milestone Farms, a Negro project in Mississippi. The men are salvaging lumber from abandoned homes and doing the work themselves—donating ten days' time apiece.

Nine of the 148 homestead projects were established for Negroes, and 30 others include some colored residents. For many of these people, adjustments to modern health methods were difficult. It was hard for Negroes at Gee's Bend, Alabama, to give up faith in the medical magic of a pair of scissors. For generations they had placed scissors under the bed "to cut away the afterpains" of



Mother brings child to health center for typhoid fever inoculation

child-bearing. But with the sympathetic guidance of a Negro nurse, they now prepare sterile packs for delivery service. And they have learned that a doctor can relieve pain more effectively than can scissors.

#### NURSING SERVICE BASED ON NEEDS

No two FSA community nursing programs are exactly alike. Each is molded to fit the problems and needs of the people, but all follow the same general pattern. The project at Ashwood Plantation in Lee County, South Carolina, one of the first to be established, is typical.

The nurse, Olive Matheny, recalls the first clinic held there five years ago. "We had to send busses out to pick up the families," she said. "In they came—fathers and mothers, boys, girls, babies. Parents were scared. The children clung to their mothers' skirts, kicked and screeched when they saw the needle. The health center was a bedlam."

Now it's different. At the last clinic, the nurse reported that even the two-year-olds walked up and asked for their

"shot." It is no longer necessary to furnish transportation. The homesteaders are notified that a clinic is to be held, and they find a way to get there.

It was not a miracle that brought about this change. It was hard work, patience, and ingenuity. Behind the scenes at Ashwood Health Center is the community nurse—guiding, creating leadership, building up an understanding of the people and their problems, seeking cooperation from staffs of hospitals, welfare organizations, school officials, and teachers. The nurse works hand-in-hand with local doctors and public health authorities. She assists them, and they in turn have helped her to develop and carry out the nursing program.

Such cooperation soon brought results. After the nurse's first year at Ashwood, she reported that typhoid fever inoculations had been given to 558 people; diphtheria inoculations to 20; and smallpox vaccinations to 39. Nearly 240 people had been examined for hookworm disease and the 39 who were infested were treated. All children in elementary and secondary schools had

been given dental examinations and tuberculin tests. One tuberculosis patient had been admitted to a sanatorium. Eight children had attended a crippled children's clinic, five had been treated, and two hospitalized. Altogether, 14 people had been admitted to hospitals for treatment that year. Fifteen people had had tonsillectomies. Eight had been fitted with glasses. Two children had been taken to a child guidance clinic. During the year 17 children were born.

#### STORIES LIE BEHIND STATISTICS

These are not just cold statistics for the nurse who knows the story behind the figures. For example, she remembers little Betty who had suffered from infantile paralysis. The child couldn't walk without aid because she had never been treated and properly fitted with braces. When she came back from the hospital, her parents said, "It seemed like a miracle when Betty got out of the car and walked by herself."

Betty was treated at the crippled children's hospital at Sumter, South Carolina. So were other crippled children from the project. In turn, Ashwood Plantation homesteaders contribute to

this and other organizations that help to meet their needs.

For example, on the President's birthday each year, they get together and stage a dance. They think President's Ball is too high-sounding a name for their homely gathering, where they have square dancing and an auction sale afterward. So they call it the Crippled Children's Dance. Every year they turn from \$100 to \$120 over to the county fund for crippled children.

One spring the homesteaders held a movie benefit to raise funds for dental equipment, now used by a dentist who comes to the project one day a week to give dental care to homestead families at special rates. The movie benefit has become an annual event. Receipts from this and several home-talent entertainments during the year are given to the county public health department. This money is pooled with the department's funds for the use of all families in the county to meet needs for special care or appliances such as eyeglasses, shoes, braces for poliomyelitis patients, and tonsillectomies.

Most likely, plans for these activities were laid at health center round-table



Negro nurse teaches a group of girls the art of making a "sick-bed"



discussions. When mothers and older girls attend monthly well-baby conferences, or when they gather to watch bedside nursing demonstrations or meet to study subjects such as personal hygiene, child care, and prenatal and postnatal care, they always find plenty of things to talk about.

#### MEDICAL CARE PLAN FOR ALL

One Wednesday in the spring of 1938 conversation was more brisk than usual. The State Medical Association had approved a medical care plan for Ashwood Plantation. "It would be something like insurance," one woman said, "only you'd be insuring for health instead of death." Each family would contribute a certain amount each year. They would pool the money and use it to pay bills for those who needed "doctoring."

Discussions that day brought forth reminiscences. One woman remembered the time that "Joe had pneumonia and we had to sell our cow to pay the bill."

Another had a sadder story: "We already owed the doctor and hated to call him again. We finally did, but it was too late to save our baby."

Before the day was over, they decided: "It would be a good feeling to know you could call the doctor without worrying how to pay him." Meetings followed at the community building, and when a medical care plan was set up at Ashwood, every family on the project joined—and so did every doctor in the county.

The medical care plan at Ashwood Plantation is similar to others being established by the Farm Security Administration in coöperation with the organized medical profession. In 900 counties of 37 states, these rural health plans are providing essential medical and hospital care for more than 100,000 farm families at a price which they can afford.

The plan is simple. For example, at Ashwood the homesteaders got together

with local doctors and the county medical society and organized an association. They elected a board of directors and named a treasurer, who was bonded, to handle all funds. Each family pays \$30 a year in advance for general medical service, obstetrical care, emergency surgery, limited hospitalization, and ordinary drugs. The pooled fees are divided into 12 equal parts. If the monthly allotment is sufficient, all bills are paid in full. If not, doctors accept a prorata share for services rendered.

Recently an examination by the State Board of Health showed school children on Ashwood Plantation to be the healthiest of any rural children examined in two counties.

#### ADEQUATE INCOME IS BASIC

But health work is only partly responsible for this record. Other things also contributed—better food, for example, and higher incomes for necessities. After moving to the project, farmers began to produce food for their own tables. They raise gardens, and keep cows, hogs, and chickens. With the aid of an FSA farm supervisor, they plant several cash crops, produce feed for their livestock, and follow sound soil-improving practices. Meanwhile, a woman trained in home economics assists the housewives—shows them how to can and store food, to prepare and cook healthful meals. In one year, families on the project increased their canned food supplies from an average of 132 quarts to 350 quarts each.

Planning is an important element in this kind of farming. At the beginning of every year, written plans are worked out by each family with the help of FSA supervisors. The plans show what crops will be planted, how much food will be needed and how it can be produced, how much money the family can expect to clear, how much they need to spend.

Once at planning time, the nurse went

to the project manager and supervisors to ask: "Could arrangements be made to include money for fireplace equipment this year?" She had a good case. One little boy had been badly burned when he had stumbled and fallen into an unprotected fire. "The money spent on that one boy," she said, "would have bought fireplace screens for every home on the project." The families themselves needed no urging. They had learned the lesson of home safety the hard way.

Sometimes they learn other things the hard way, too. On one project, a family refused to have toxoid and lost a child with diphtheria. The others were immunized immediately, and the following week two neighboring families made their first appearance at the clinic.

But once they become health-conscious homesteaders soon spread the word to families in surrounding areas—and there are no fences around any of the projects. One nurse estimated that 60 percent of the children she inspected and weighed during the year came from the outside. FSA community nurses extend their work to the outside, too. They provide service in areas where there are no

county health programs, or supplement the work of existing programs. That is a fundamental principle of project nursing programs.

#### GOOD NEIGHBORS VOLUNTEER HELP

In a community where people have similar problems and needs, the nurse has plenty of volunteer helpers. Take the Good Neighbors, for example. Good Neighbors are women who offer their services for bedside nursing. They learn to give bed baths, to care for new babies and mothers, and to perform other bedside nursing duties. In return, these women call for similar help when they need it.

Good Neighbor volunteers serve on all projects where there are nursing programs. So do health committees. The three women on a health committee visit their neighbors, explain the need for vaccinations and other preventive health measures, and pave the way for follow-up visits by the nurse. They also sponsor clean-up days, and keep things running smoothly at health-center clinics while the nurse is busy assisting the doctors.

"Without this kind of coöperation, an adequate nursing program would be im-



Expectant mothers at antepartum clinic learn maternal hygiene and infant care

possible," one nurse said. "That's one thing I like most about the work here. You have a chance to get things done. You have the cooperation not only of the families, but of the farm and home management supervisors, the project manager, the supervisor of community activities, and the local teachers. Their

work lays the foundation for good health. Nursing services and adequate medical care do the rest."

In this nurse's words can be found the key which opens the door to rural communities of healthy, happy people.

The pictures in this article are by courtesy of the Farm Security Administration.



## ELECTRICITY FOR RURAL CENTERS

PUBLIC SCHOOL officials in some 20,000 rural school districts obtaining electric service from systems financed by the Department of Agriculture's Rural Electrification Administration have received invitations to serve on committees to establish nutrition centers in their communities. The centers, electrically equipped, are being financed by REA loans made by power cooperatives to school districts. They will enable rural areas to participate more fully in the countrywide nutrition program which grew out of the National Nutrition Conference held in Washington, D.C., in May 1941.

The kind of equipment appropriate for a particular school depends on the number of pupils, the grades included, the available space, and the financial ability of the community to repay the cost within a reasonable time. Moderate-sized schools may plan for an installation costing from \$150 to \$300. Basic equipment would include a refrigerator, pressure water system, electric range, dehydrator, and grinding mill. A small one-room school could be

equipped with a single unit hot-plate, an 18-quart roaster, and a small flour mill for as little as \$50. In such schools, a pressure water system would also be desirable.

Larger schools might justify installation of a bigger flour mill and a walk-in type of refrigerator provided with a zero box and dehydrating unit. This would afford thoroughly effective facilities for preservation of meats, fruits, and vegetables for the school. The large flour mill grinds better and faster. Such a center would be of real value to the whole community.

Even the most inexpensive of these installations would make it possible for the school to provide hot lunches without fire hazard, and to carry on canning demonstrations and classes for young people and adults. Surplus foods could be canned for school lunches; fresh whole wheat flour, grits, and meal could be ground; and the grinding mill could be made available to the families of school pupils for grinding the protective flour and meal which they need for their own use.

## Curriculum Guide Nears Completion

A final progress report on the curriculum guide for public health nursing by the chairman of the committee

SINCE the last progress report of the Committee to Study the Public Health Nursing Curriculum, there has been accelerated activity with corresponding accomplishment. When one considers that over two hundred individuals have been involved in this activity through membership on or as consultants to sixteen production committees distributed throughout the country, with reviewers who are authorities in each of the health areas, it is clear that this has become a national undertaking with widely representative participation. Too much cannot be said in appreciation of the work of the production committees, representing approved programs of study and the various types of public health nursing service and administration, which resulted in the submission of all of their reports by last September. The next step has been the referral of these reports to the reviewer-specialists who have given generously of their time and thought, making many valuable comments and suggestions.

What is the present status of the study? At a meeting of the central committee, to which the production committee chairmen were invited, on October 11 at Atlantic City, several important decisions were made for the completion of the report. The secretary, Mary J. Dunn, was authorized to proceed with the editing of the material from the production committees so that there might be an adequate degree of uniformity in method of presentation, and to incorporate suggestions from the reviewers. The committee also voted to appoint a small executive committee of eight—with representation from the central com-

mittee, the production committee chairmen, the Education Committee of the National Organization for Public Health Nursing, and the United States Public Health Service—with power to act in bringing the joint project to completion.

This was no small assignment that was handed to the executive committee. It meant not only that final detailed decisions as to content had to be made but also that this group was to act as the production committee for several important sections of the curriculum not included in the sixteen health areas—such as principles of public health nursing, organization and administration, and methods of health education. At a two-day and half-the-night meeting, the executive committee tackled these responsibilities, much preliminary work having been done by Miss Dunn. During these days of concentrated consideration the major steps were taken for the rounding out of the report, and the outlining of the work still to be done during the next few months.

The central committee has set as its definite goal the distribution of the guide at the 1942 Biennial Convention. There have been various unavoidable delays which make that goal difficult to reach. However, the Biennial Convention remains the goal—even though this means very great pressure in completing the work. In this connection, the approach of the central committee to the whole undertaking should be recalled. The committee has been concerned with the knowledge, attitudes, interests, abilities, and professional skills the public health nurse should have in order to function effectively and with professional competence in relation to the health needs of individuals, families, and the community, and in relation to the public health program as a whole and

in its parts. In calling the final result of this Committee a "curriculum guide," emphasis is placed on the second word. The guide also might be called a first progress report, on the assumption that there will and should be revised editions as the years go on, and the functions of the public health nurse change in a world of changing scientific knowledge and social organization. Also the gaps—possibly one should say the sins of omission and commission—will become evident through use. Therefore if the report serves as a guide to the next steps leading to constructive changes, it will fulfill its purpose as the first major step in attempting to define the objectives and content of public health nursing preparation.

These comments properly belong in the introduction to the published material and will be there with amplification. They are included here as a preliminary introduction in this last progress report before final production takes place. In the last two years since this joint project was undertaken one has often heard,

"Let us wait until after the curriculum study committee has made its report before going any further with that question." This reaction is quite natural and appropriate if it is realized that this or any other such study may raise questions as well as answer them. In no sense is the guide didactic as to what is the right way or the wrong way. In fact it does not deal so much with ways or methods as with objectives and with content which could be used in a variety of ways so long as the objectives are achieved. Certainly it also includes suggestions as to ways of learning and of developing the professional capacity of the individual to meet situations, but these suggestions are not in the form of lesson plans nor a prescribed curriculum.

The next progress report on this joint project of the N.O.P.H.N. and the U.S.P.H.S. will be "A Curriculum Guide for Public Health Nursing!"

KATHARINE TUCKER, R.N.

*Chairman, Committee to Study  
the Public Health Nursing Curriculum*

## HOMEMADE MERRY-GO-ROUND



A BABY-WALKER and merry-go-round improvised by the father of these

19-months-old twins provided play and exercise for the toddlers. During the cold weather a vacant room was utilized. A pole was sharpened and inserted in holes in the floor and ceiling so that it would revolve. An eight-foot cross board was attached eighteen inches from the floor, leaving four feet on each side of the vertical pole. This cross board acts as a walker. The children are placed in a loop made of a flexible limb attached at each end of the crosspiece. The invention kept them busy and happy.

TALMADGE S. FERGUSON, R.N.

*Pickens County Health Nurse  
Carrollton, Alabama*



# Health Service in an Iowa College

By EVELYN C. STREET, R.N.

PARENTS of college students are naturally concerned about the welfare of their sons and daughters. To their anxious query, "What if he should get sick?" they are beginning to expect more and more in the way of a satisfactory answer and the college feels an ever-increasing responsibility to give them one. For the small liberal arts college, the provision of an adequate student health service offers special problems.

In a study of 69 colleges Dr. Harold Diehl found that there were 0.3 to 0.9 full-time physicians for every 1000 students, and he concluded that, "Evidently small schools depend upon nurses to conduct many of the health service procedures which are carried by physicians in the larger colleges."\* A survey of nursing service in 65 colleges in five north central states by Fern A. Goulding showed that 82 percent employed full-time nurses, but only 15.4 percent, full-time doctors and nurses.\*\*

Is it possible for the small college to give parents assurance that the student will be properly cared for? Many small colleges are demonstrating that an effective health program can be carried on. The plan must be conceived and administered by personnel trained in health education, with an understanding not only of student needs but of community facilities. A good working arrangement with the physicians is particularly important.

The health service for the 350 women students of Coe College in Cedar Rapids, Iowa—a college of eight hundred students—has been in operation for twenty years. The program of the Department of Health and Physical Education is under the direction of the college nurse and the directors of physical education.

## MEDICAL EXAMINATIONS

Before entering college the student receives a health form. She fills out one side of the blank, giving her family history. The other side is filled out by her family physician and sent directly to the college. These cards are studied by the nurse and directors of physical education before the student arrives. Any abnormality recorded by her physician, or any unusual family situation—such as chronic illness in the home or the death of parents—is noted. Thus the college health personnel have a picture of the student before she arrives on the campus.

During freshman week, two physicians from the community conduct medical examinations at the college infirmary. The student's health card giving the home physician's appraisal is in the hands of the physician at the time of this examination. The ability of the student to carry a normal mental and physical load is determined, and the doctor makes suggestions regarding her college program, which are recorded and become the basis for the follow-up work of the health service. Tuberculin patch-testing is routine for entering students, with x-ray examination of all positive reactors. During the medical examination each student is alone with the

\*Diehl, Harold. *The Health of College Students*. American Council on Education, Washington, D.C., 1939, p. 80.

\*\*Goulding, Fern A. *A Study of College Nursing Services*. *PUBLIC HEALTH NURSING*, May 1940, pp. 319-329.

doctor and the recorder—who is the nurse or physical educator.

#### PHYSICAL EDUCATION FOR ALL

Physical education is required of all students for the first two years. No student is excused from participation. The examining physician may suggest more or less strenuous activity but he never advises that the student shall have no activity at all, because the program offered is so varied that something can be found to suit every individual. This provides for the needs of the girl who has always secured an excuse from all forms of activity, either because the high-school program was limited to strenuous games in which she could not participate, or because she did not like the work. Such a girl offers a challenge, and an effort is made to find—from among a large number of activities—something that she really enjoys. It is gratifying to open up for such a student new areas of experience, holding opportunities for health and enjoyment that she has missed.

#### SICK STUDENTS RECEIVE CARE

A five-bed infirmary adjoining the nurse's office in the women's residence hall serves 190 residents. Here they may come with minor ailments or injuries, for clinical service and first-aid care, advice on health matters, or care in bed if needed. Infirmary care is free to the student, but she pays the fees of the physician whom she calls for medical care.

No student calls or visits a physician without first reporting to the nurse. The student may, however, always consult the physician of her choice. If she has no choice the nurse refers her to a physician. Our records show that during a school year 20 to 25 doctors—including specialists in eye, ear, nose, and throat, x-ray, skin diseases, and other fields—are asked to serve our students. It is the responsibility of the

college nurse to see that every student who needs medical care receives it. But her responsibility does not stop there.

College health personnel are too often considered specialists offering a service which is quite apart from the general objectives of the college. The Coe College health service is interested, like every other department in the college, in the education of the student. Its usefulness must be measured by what it is able to contribute to the student's welfare and education.

The health office is a depository for student woes—both physical and emotional. Those in charge realize that the information they have about a student is often enlightening to others who work with her and may help them to understand the student better. Printed slips are used to notify the professors when their students are ill in the infirmary. If more detailed information is needed, a conference is more satisfactory than a note. The sharing of information about a student may be helpful to the nurse as well as to the professor.

Although there is no psychiatrist in the city where the college is located, some of the local physicians are particularly interested in emotional problems of students and can be called upon for help when needed. Students with more serious problems are referred to psychiatrists at the clinic of the State University Hospital, 26 miles away.

The nurse assumes responsibility for keeping parents of sick students informed regarding their condition. She writes parents of out-of-town students who are ill in the infirmary or under medical care. She also makes an effort to become acquainted with parents when they come to the campus.

#### NURSE AN EDUCATOR

The college nurse welcomes the opportunity to teach both in the classroom and individually by using the opportunities offered in her daily contact with the stu-

dents. The nurse at Coe College teaches freshman hygiene, health education, health administration, and the Red Cross courses in first aid and home nursing.

The nurse has every opportunity to familiarize herself with the family background, physical condition, habits, work, and aims of the students. They live in the controlled environment of the residence hall which offers to each individual an experience in wholesome living, with pleasant surroundings, proper food, regular hours for study and rest, companionship, and recreation. Conformity to the life of the hall means following the simple rules of hygiene. Those who persistently fail to conform, who miss their meals, do not get enough rest, or who fail in their relationships with other people need special attention. Many of the health problems of college students result from ignorance or indifference, or from wrong attitudes toward the whole

problem of how to live a well balanced life. The Department of Health and Physical Education aims to help the student toward achievement of that objective, and the response of the students to the health program is gratifying.

Never before have we been so conscious of the importance of health education for college youth. Never have we been so sure of the necessity for helping them to realize health in its broadest aspect. "The nation needs men and women of strong physique, courageous, intelligent, clear thinking, loyal to significant causes, and eagerly devoted to human values. These are also the needs of persons and hence the concern of hygiene."\*

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\*Williams, Jesse Feiring. *Personal Hygiene Applied*. W. B. Saunders Company, New York, seventh edition revised, 1941, foreword to the student.

### RED CROSS ENROLLMENT GOES UP

THE DECLARATION of war offered a great stimulus to enrollment of nurses in the American Red Cross, and the number enrolled in the First Reserve during December 1941 rose to over 1500 as against 440 in November. The majority of those enrolled in December indicated that they would be available for service early in January or February. The Red Cross hopes to enroll at least 2000 First Reserve nurses a month in order to build up a sufficient reserve to meet the needs of military service.

The requirements in regard to the physical examination have been changed in order to stimulate enrollment and to obviate the necessity for two examinations. Instead of a physical examination, applicants will submit answers to

the first eight questions on the examination blank—which includes information on weight, vision, family history, and past medical history—and will make a statement on the reverse side in regard to their general physical condition and disabilities. The usual physical examination of those volunteering for military services will be made by the Army and Navy after the nurse's enrollment in the Red Cross Nursing Service.

The Second Reserve is also being built up from transfers out of the First Reserve. Nurses up to 50 years of age who are not eligible for the First Reserve but who are able and willing to give volunteer service in local activities may enroll in the Second Reserve if they meet other enrollment requirements.

# Paper's Challenge to Public Health

By BEULAH FRANCE, R.N.

**Paper is used today in an astonishing variety of ways in school, industry, and home to prevent the spread of communicable disease and save unnecessary labor**

PAPER and public health are inseparably linked together today. The public health nurse, as a teacher, recognizes the value of paper in the prevention of the spread of disease.

The hazard to health of improperly cleansed eating utensils has been convincingly proved by many studies of the number of bacteria found on so-called clean dishes used in public places. Dr. James G. Cumming pioneered in the field of sanitary dishwashing back in 1917.<sup>1</sup> His suspicions were aroused as a result of observations at a California army camp in that year. Why couldn't, thought he, contaminated cups and dishes play a part in the transfer of virulent germs from one person to another?

Acting on this theory, Dr. Cumming spent years in research in this field of public health protection. His studies and findings have been widely published and read. It was he who found that influenza-pneumonia<sup>1</sup> broke out three times as often among people who ate from carelessly cleansed dishes as it did among those using sanitized utensils.

It was he who found, too, that very often dishes come out of "cleansing" baths more dangerous to health than before their immersion, since they gather added germs from the water. Even when dish-washing machines were used, samples of the wash water were found to carry 300,000 organisms per cubic centimeter.<sup>2</sup> When dishes are washed by hand, such contaminated water leaves the hands of the washer so bacteria-

laden that they constitute a public health hazard.

Particularly dangerous are carelessly washed drinking glasses since they come into direct contact with the mouth. Bacteriological tests<sup>3</sup> have shown that a soda fountain drinking glass may harbor on its rim as many as 23,000 bacteria while a paper cup has an average of two.

## HEALTH IN THE SCHOOL LUNCH

Since school children patronize restaurants and soda fountains, do not such facts challenge every school nurse to investigate places providing refreshments, both in and near the school? The cafeteria, lunchroom, and corner drug store are often careless in cleansing their dishes and drinking glasses. Proprietors will listen to the nurse for they know the influence she exerts. It is she who can tell them to install sanitary, single-service paper cups. It is she who can educate the school board to the point of replacing, with paper common towels and drinking glasses.

Thanks to the educational work of school nurses among parents, today's school lunch-box contains more eggs, fruits, vegetables, and milk products. Mothers are happy to hear about paper cups and containers which will not be brought back for washing. They're delighted to learn that such soft foods as custards, cup cakes, whole wheat muffins, and baked beans can be carried in the unwaxed paper containers they were cooked in.

Appetizingly packed in paper containers is this school lunch of bean soup, vegetable salad, baked apple, whole wheat sandwiches, muffin, and milk



Nurses now assemble and show several samples of these one-time-use utensils, explaining that waxed cups are not meant for hot foods, but that salads keep fresh in them, while nutritious fruit juices, soups, milk, and chocolate drinks do not soak through those containers which have been made moisture-proof. They point out the increasing use of properly sterilized paper milk bottles. They show how to handle and care for paper covers on glass milk bottles, emphasizing that if milk must be purchased in glass bottles, only those protected with paper hoods which extend well down over the bottle neck are safely sanitary.

Variety of food today replaces yesterday's sandwich and cookie noonday nibble. Pretty paper plates and gaily-colored paper napkins; decorated individual paper cups; attractive paper pepper and salt shakers; paper containers packed full of nutritious surprises—these do away with the practice of re-

turning to the lunch-box dirty dishes which make more work for mother and less health protection for the child.

But can parents afford to send paper to school every day? The cost is surprisingly low. A sufficient supply of paper containers to last a whole school year can be purchased for around two dollars. In fact if a group of mothers pooled their paper cup and container money and purchased in large quantities at a time, the cost per parent might fall below two dollars a year for each child.

#### INDUSTRY BECOMES PAPER-WISE

Nurses in industry have instituted many reforms recently which have cut costs and increased production. Among the ideas working well are cafeterias on wheels circulating from floor to floor continuously, timed to return at definite intervals of  $2\frac{1}{2}$  hours, providing the workers with nourishing refreshments and a chance to relax. Paper plates, cups, and napkins are used exclusively.



Are all factories paper-wise today? Let's look at two different reports from one state—Pennsylvania. A mill in Philadelphia engaged an industrial nurse. She saw to it that paper cups and shower baths with paper towels were installed. This firm has found there is profit in prevention. And yet a study<sup>4</sup> made in 1934 of 16,000 manufacturing establishments in Pennsylvania showed that in one fourth of the factories workers were using common drinking cups and common towels, while in 600 plants there were no drinking facilities.

What a challenge to the nurse in industry! For is it not the industrial nurse who can best bring about needed sanitary reforms in plants and factories?

In plants where industrial workers are submitted to intense heat, nurses see that salt tablets—ordered by the physician—are provided, with plenty of water and individual paper cups. In defense plants, bakeries have sprung up to meet nourishment needs. Here paper has been purchased for cooking, serving, preserving, and storing foodstuffs. From the tiny squares used for butter chips to the gallon-size containers, paper saves time, labor, and expense.

In more than one location where Army maneuvers are to be carried on, local health officers and Army medical authorities are taking action to ban the use of infection-spreading glasses, recommending the substitution of paper utensils which are used only once, and discouraging or prohibiting the patronage of establishments which do not comply with high sanitary standards in regard to eating and drinking utensils.

#### PAPER IN THE PRIVATE HOME

The public health nurse who makes home visits for instruction and bedside care will also find paper an invaluable aid in the carrying out of her double duty—prevention of illness and relief for those who are sick.

\* Paper handkerchiefs, napkins, towels, and aprons are already accepted as part of the educational equipment for practically every visiting nurse. But have paper cups and containers also been added? They might well become a positive part of instruction given for bedside care of the sick.

On many farms a common tin dipper for employer, employee, and the whole family of children rests in the water pail when not in use. And when more water is dipped up than is needed, the surplus is very often thrown back into the pail! Would it not be ideal if a dispenser of paper cups by every kitchen sink and water pail could be the rule?

Communicable diseases are cared for at home in the country perhaps more frequently than in urban areas. But wherever they may be, the challenge of paper is present. Paper spread on the sickroom tray; paper napkins, drinking tubes, sputum cups, bed pads, bedpan covers, as well as covers of bedclothes; paper gowns to protect the clothing, paper masks to cover the nose and mouth, and paper caps for the hair of the attendant; paper curtains, inserts for infants' diapers, bags or containers for burnable refuse, tissues for nasal discharges; toilet paper and paper containers for contaminated food and defecations which must be rendered harmless before being emptied out—these are all aids toward prevention of the spread of communicable diseases, including the common cold.

Would it not be well if every household would treat common colds with as great respect as they do measles or scarlet fever? They undoubtedly would if they fully realized how many serious illnesses the cold may pave the way for. The public health nurse has to teach, in each home visited, the prevention of this danger.

And what if families should realize too that influenza, scarlet fever, measles, diphtheria, and tuberculosis are among

the diseases spread by drinking glasses? Are not nurses working in schools, industries, and homes the ones who are challenged to teach them?

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<sup>2</sup> Cumming, James, and Yongue, N. E. "Eating Utensil Sanitation." *American Journal of Public Health*, March 1936, 237.

<sup>3</sup> Barrett, Rollin H., Fellers, Carl R., Novick, Julius. "A Clean Service for Every Customer Every Time." *The Sanitarian*, May 1940, p. 5.

<sup>4</sup> Women's Bureau, U. S. Department of Labor. *The Occurrence and Prevention of Occupational Diseases Among Women*, 1941, p. 29.

## A Health Program for Rejectees

THE NEED for a program to correct health defects and give necessary medical care to draftees who fail to pass the physical examination was early recognized in our community. The county has almost every facility for good public health work—hospital and dispensary service, clinics of all kinds, a fine medical corps, and well prepared public health nurses. In order to make these available to the young men who need care, the Monmouth County Organization for Social Service—which is the coördinating health agency in the county—called together the agencies and individuals most concerned with the health of rejectees. Participating in a conference to discuss the situation were representatives of all the draft boards, the medical and dental professions, and the medical division of the governor's staff, together with some of the leading lay people of the county.

Of course, we wanted a list of the men who had failed to pass the physical examination and the causes for their rejection. Our plan was to urge the young men to have their defects corrected and to direct them to facilities for care in the county. Those able to pay would be urged to go to their own physicians. Those who could not afford a private physician would be informed of the facilities for having defects cor-

rected and the importance of prompt medical care. Under existing regulations, it was impossible to get the information desired from the draft boards. Finally, a compromise was reached. Posters bearing the following text were prepared, to be hung in all the draft board rooms:

#### Have you physical defects?

Their correction is important in peace or war.

Do you need help in having your defects corrected?

Do you know where to go for help and advice?

There are agencies in Monmouth County which are ready to serve you.

The examining physician or clerk of the selective service board has a list of these agencies.

Fliers were also printed containing the name and address of every health center in the county, the office hour and name of the supervising nurse, and the telephone number, together with the following text:

#### Selective Draft Service

Monmouth County, N. J.

#### Have you physical defects?

Their correction is important in peace or war.

Do you need help in having your defects corrected?

If so, phone or call at any of the following centers.

The public health nurse in charge will be glad to help you make your plans.

One of these fliers is given to each man as he goes in for medical examination. If he is accepted for the service, he may throw it away. If not, he knows where to go in order to get help and advice.

The results have been good. It is impossible to say how many of the young men have actually followed the advice given, but we know that a great many have done so. For instance, several of these young selectees were already in our county sanatorium for tuberculosis when we received the official notice from the State Department of Health that they had been diagnosed as active tuberculosis cases.

Each community will of course develop a plan based on its own needs and

resources. From our experience we would make this suggestion: When you have facilities, don't wait for something to happen, but get together all of the people concerned, for a conference around a table. You will find that they are just as anxious to do something about it as you are, and will do everything in their power to cut red tape.

EVELYN T. WALKER, R.N.

*Director, Health and Welfare  
Monmouth County Organization for  
Social Service, Red Bank, New Jersey*

## School Panels at A.P.H.A. Meeting

**L**ARGE and interested audiences attended the two panel discussions on various aspects of the school health program at the annual meeting of the American Public Health Association, Atlantic City, New Jersey, October 13 to 17, 1941.

"School Health Information, Please" was the subject of a discussion by a "Board of Experts" in a joint meeting of the Public Health Education Section and the American School Health Association. Six specialists in various aspects of school health under the chairmanship of Dr. Arthur R. Turner discussed important problems in the school health program, with emphasis on the purpose and conduct of the school health examination, and the objectives and methods of health education in the schools. For the one-room school, a schoolwide study of health problems, with each group working on its own level, was suggested. Some difference of opinion was expressed as to the desirability of a more organized approach for older age groups, especially in certain school situations. But there seemed to be agreement with Sally Lucas Jean on the fundamental purpose of health edu-

cation—that children should leave school having a definite concept that there is a body of scientific knowledge on which the approach to health problems should be based. The question as to whether teacher and parent should always be present at the school health examination was discussed pro and con from the standpoint of practicality and desirability. The importance of an educational program as to what constitutes a good examination was brought out, together with the need for making the examination an educational as well as a pleasant experience for the child.

Those participating in the panel were:

Arthur R. Turner, M.D., School Physician, Department of Education, University of Chicago, Chicago, Ill.

Ruth E. Grout, Ph.D., Senior Supervisor of Health Education, Department of Health and Safety, Tennessee Valley Authority, Chattanooga, Tenn.

Sally Lucas Jean, Executive Secretary, Health Section, World Federation of Education Associations, New York, N. Y.

Alice V. Keliher, Ph.D., Assistant Professor of Education, School of Education, New York University, New York, N. Y.

Earl E. Kleinschmidt, M.D., Director, Department of Preventive Medicine, Public Health and Bacteriology, Loyola University, Chicago, Ill.

W. Carson Ryan, Ph.D., Professor of Education, University of North Carolina, Chapel Hill, N. C.

Charles C. Wilson, M.D., Professor of Health and Physical Education, Teachers College, Columbia University, New York, N. Y.

Rural health and educational experts conferred in a lively discussion panel on "Planning the Nutrition Content of a School Health Program in a Rural Area" under the chairmanship of Dr. George M. Wheatley. Discussants represented those individuals who are most concerned with a rural school health program: the county superintendent of schools, county health officer, public health nurse, county medical society representative, state nutritionist, home demonstration agent, Red Cross and county welfare department representative, and classroom teacher.

Many practical suggestions were offered to meet the problems of securing adequate nutrition for rural families, including methods to provide a hot dish in the one-room rural school; use of surplus commodities; stimulation of home gardens and the use of school canning equipment to help low-income families improve their diets; promotion of year-round school gardens; preparation and serving of lunch by the children as part of the curriculum; and utilization of all available resources in the community, such as the medical society nutrition

committee, the local Red Cross Chapter, and the agricultural extension facilities of state colleges and universities. Emphasized throughout was the fact that a well rounded nutrition program must include not only the school child, but the entire family. Parent education and the active participation of parents and children in any program were stressed. Nutrition councils, many of which already exist, were considered a practical means towards developing nutrition programs which include the school and the community.

#### Members of the panel were:

George M. Wheatley, M.D., Assistant Medical Director, Metropolitan Life Insurance Company, New York, N. Y.

Marie Doermann, Nutrition Specialist, Extension Service, New Jersey State College of Agriculture, New Brunswick, N. J.

Vivian Drenckhahn, Lecturer in Health Education, University of Michigan, Ann Arbor, Mich.

Paul R. Ensign, M.D., Assistant Director, Division of Child Hygiene, State Department of Health, Topeka, Kans.

Catherine Leamy, Nutritionist, American Red Cross, Washington, D.C.

Margaret A. Lewis, Field Representative, American Red Cross, New York, N. Y.

J. Louis Neff, Executive Secretary, Medical Society of Nassau County, Mineola, N. Y.

Alice Sue Simmons, Assistant Supervising Nurse, Lauderdale County, Meridian, Miss.

Calvin Smith, Superintendent of County Schools, Seminole County, Okla.

### AMERICAN JOURNAL OF NURSING FOR FEBRUARY

Malaria	Linus E. Rausch, M.D., and Nell E. Mills, R.N.
Local Application of the Sulfonamides	Donald E. Dial, M.D.
The Sulfonamides	Lucy E. Allen, R.N.
Physical Comforts	Anna M. Taylor, R.N.
Your 1941 Federal Income Tax Return	H. A. Withey
Uses for Paper Cups and Containers	Beulah France, R.N.
Recruitment of Student Nurses	Elsa Winifred Lowe, R.N.
Red Cross Home Nursing and the Baby's Schedule	Virginia Boyer Miller, R.N.
Nursing Answers	Frances Payne Bolton
Nursing Schools and National Defense	
Speeding Up Production of Nurses	Margaret Tracy, R.N.

# Similarities and Variations in Programs

By DOROTHY E. WIESNER AND MARGARET M. MURPHY

An interesting picture of public health nursing programs is shown in the findings of the Yearly Review made by the National Organization for Public Health Nursing

MUCH is being said these days about making the most use of available public health nursing facilities. Besides the traditional programs of home visiting and clinics, certain other important services have grown out of community needs. These include school nursing, orthopedic work, industrial nursing, and follow-up work. So much interest has been shown in the types of programs—both generalized and specialized—of public health nursing agencies that replies about these from 600 agencies sending in Yearly Reviews in 1940 have been summarized. About 1000 schedules were mailed, and 600 replies with data which were worth tabulating were received. This review shows the similarities and variations, by geographical sections and by types and sizes of agencies of (1) school nursing (2) orthopedic work (3) industrial nursing (4) follow-up work.

The sample represents about 10 percent of the total number of public health

nursing agencies in the United States. Efforts were made to have the sample follow the proportions in the total in regard to size and type of agency and geographical areas. Of the 600, only 11.5 percent were large agencies employing 25 or more nurses; 17.3 percent employed 10 to 24 nurses; more than half, 53.4 percent, employed 2 to 9 nurses; and 17.8 percent were one-nurse agencies.

The division is more even so far as type of agency is concerned. Of the total number, 35.0 percent were nonofficial agencies; 34.2 percent were nursing services in boards of education; 28.0 percent were services in health departments; and only 2.8 percent were the interesting "combination" agencies—those in which administration and program and support are so combined that they are neither official nor nonofficial.

So far as geographical location is concerned, the Midwestern states are represented more heavily among the total

TABLE I  
AGENCIES IN THE SAMPLE BY GEOGRAPHICAL AREAS ACCORDING TO TYPES

By geographical areas	Total all types	By type of agency			
		Health department	Board of education	Non-official agency	Combination agency
Total, all areas	600	168	205	210	17
New England	123	18	36	67	2
Middle Atlantic	124	20	39	61	4
Middle West	188	50	77	55	6
South	94	56	20	14	4
West	70	24	33	12	1
Territory	1	—	—	1	—



TABLE II  
SCHOOL NURSING<sup>1</sup> IN PUBLIC HEALTH NURSING AGENCIES

By types of agency	Total agencies in sample	By replies about school nursing			
		Reporting school nursing service		Reporting no school nursing service	No reply about school nursing service
		Number	Percent		
Total agencies in sample	600	433	72.2	142	25
Health departments	168	146	86.9	17	5
Boards of education	205	205	100.0	—	—
Nonofficial agencies	210	69	32.9	121	20
Combination agencies	17	13	76.5	4	—

<sup>1</sup>Including work in public, parochial, private, and nursery schools.

number of known agencies, 31.3 percent of the 600 in the sample being in these states. There are 20.7 percent in the Middle Atlantic states; 20.5 percent in New England; 15.7 percent in the Southern states; and 11.7 in the Western.\*

From this description of the sample of 600, let us turn to some of the special programs carried on by the agencies to see how many are assisting in community health work by services other than home visits.

#### SCHOOL NURSING

Questions were asked separately about nursing services in (1) public schools (2) parochial schools (3) nursery schools (4) other private schools. Almost three quarters of the 600 agencies did school nursing in one or more of these four types of schools, although only one third of the 600 were board of education services. Table II shows that school nursing in at least one kind of school was part of the work of 86.9 percent of the 168 health departments, and 32.9 percent of the nonofficial agencies.

##### 1. School nursing under health departments

About two thirds of the health depart-

ments were active in public school work. In the Southern states, 80.4 percent of the 56 health departments reported work in public schools. At the lower extreme in this comparison are the health departments in the Middle Atlantic states, in which only 30.0 percent reported public school work.

So far as parochial school nursing is concerned, the New England health departments showed such work most frequently, and the Southern health departments least frequently. In this connection it is of value to remember that in New England almost 10 percent of the school buildings are for parochial schools, whereas in the South (which includes 16 states in this study) only 2 percent of the school buildings are for parochial schools.\*\*

Forty-eight of the 168 health departments reported work in nursery schools. Sometimes this was because the nursery school was located in the school building, or because the school was a special project. Twelve health departments reported service to private schools. One mentioned that it gave service upon invitation, or for communicable disease work. One Seventh Day Adventist school service was mentioned.

\*For lists of states included in these categories see "Going Forth," by Louise Hopwood, PUBLIC HEALTH NURSING, November 1939, pages 624-632.

\*\*U. S. Office of Education. Statistics of State School Systems, 1937-1938. Bulletin 1940, No. 2, Chapter II. U. S. Government Printing Office, Washington, D.C., 1941.

Of the 146 health departments reporting some kind of school service, only 43 stated that the work was specialized—that is, that specialized nurses were employed. Thirteen health departments employed specialized supervisors, and 43 health departments employed from one to 130 specialized staff nurses. Chicago, Detroit, San Francisco, and Philadelphia health departments had large staffs of specialized school nurses.

Six health departments reported activity in all four types of school nursing—public, parochial, nursery, and private schools. The only section of the country not represented among the six is New England.

Health departments reporting nursing service to four types of schools:

New Jersey—Rutherford, Bureau of Maternal and Child Health, State Department of Health

Michigan—Detroit, City Department of Health

Wisconsin—Milwaukee, Division of Field Nurses of the City Health Department

Kentucky—Louisville, Bureau of Public Health Nursing, Department of Health of Kentucky

Maryland—Baltimore, Baltimore City Health Department

California—San Diego, County Health Department

## *2. School nursing under boards of education*

Boards of education made up 33.7 percent of the 6166 agencies reporting to the U. S. Public Health Service in 1940, and they comprised 34.2 percent of this sample of 600. Every board of education was serving the children in public schools. Of the 205 boards of education, 139, or 67.8 percent, served in public schools only.

So far as service to parochial school children is concerned, the health departments are more likely to function. In our sample, 66.7 percent of the 168 health departments, and only 23.9 percent of the 205 boards of education reported service in parochial schools.

As far as geographical location is con-

cerned, boards of education participated in parochial school work most frequently in the New England states and least frequently in the Southern states, as did the health departments.

Nursery school work was reported by only 29 boards of education, 11 of these being in the Middle West. Five boards of education reported service to private schools, but the three that named the private schools indicated a misunderstanding of the term "other private schools." The private schools listed by them included a state teachers college, a kindergarten, and a vocational and adult school.

Twenty of the 205 boards of education reported nurses engaged in a particular activity, and 13 of these were Midwestern organizations. Thirteen of the 20 employed 17 orthopedic nurses, and 11 of these 13 were Midwestern agencies. The 20 organizations employed 38 nurses for special activities in the schools. The following activities—besides orthopedic service for which full-time nurses were employed—were mentioned: audiometer and other hearing acuity work, 7 nurses; visual acuity work, 3 nurses; Mantoux tests and immunization, 2 nurses; dental health, 2 nurses; clinic, 2 nurses; special classes, 2 nurses; and one each for nutrition, service to school employees, and home visits to children with special problems.

## *3. School nursing under nonofficial agencies*

Of the 210 nonofficial agencies in this review, 69 or 32.9 percent supplied school nursing of some kind. Thirty-two agencies supplied nursing in public schools, 27 in parochial schools, 20 in nursery schools, and 16 in private schools.

A greater proportion of nonofficial agencies did public school nursing in the Middle Atlantic states than elsewhere. None of the 12 nonofficial agencies in the Western states in this

sample gave service in the public schools.

So far as parochial school work is concerned, the nonofficial agencies in the Middle Atlantic states again appear to be more likely to do this than in other areas. In New England and in the South they are less likely to do parochial school nursing.

The proportion of nonofficial agencies participating in nursery school work is less than among the official agencies. Why the Middle Atlantic states' nonofficial agencies should be so much more active in school work than similar agencies elsewhere remains an interesting but unexplained question. In both nursery school work and private school work, the Middle Atlantic states show nonofficial agencies more active than similar agencies in other areas.

Of the 69 nonofficial agencies active in at least one kind of school nursing, only 12 employed specialized workers for school service, and only 3 employed specialized school nursing supervisors. These three were Lancaster and York, Pennsylvania, and Denver, Colorado.

Payment to nonofficial agencies for public school nursing is far from unusual. Of the 32 agencies working in public schools, only 3 stated they were not reimbursed, although 4 others failed to answer the question. The amount of reimbursement varied from \$125 a year to \$7700. Thirteen agencies received less than \$1000; 9 received from \$1000 to \$2999; and 3 received more than

\$3000. Payment was usually according to the amount of time used for the service.

Payment to nonofficial agencies for parochial school work is also customary, although 9 of the 27 agencies in this group reported they were not reimbursed. The amounts reported by 17 agencies varied from \$44 to \$5189. The most frequent method of reimbursement was on a time basis.

Payment for nursery school work was less frequent than for the other types of school work. Only 11 of the 20 agencies in this group reported payment, and none received more than \$350. The visit basis for payment was used in 5 places, and in 6, the amount of time decided the payment.

The amount of payment to the visiting nurse association for work in private schools was also on the visit basis. Of the 16 agencies of this kind working in private schools, 13 reported payment, the largest single yearly amount being \$900, in an agency whose offices are located in the building of an endowed school for girls.

#### 4. *School nursing under combination agencies*

There were only 17 agencies in the state of combination at the time these schedules were returned. One would wish to report they were all so thoroughly combined that all provided school nursing, but only 13 of the 17 did so.

TABLE III  
NURSING SERVICE TO BOTH PUBLIC AND PAROCHIAL SCHOOLS BY TYPE OF AGENCY

By geographical areas	Total agencies serving public and parochial schools	By type of agency			
		Health department	Board of education	Non-official agency	Combination agency
Total, all areas	145	79	49	11	6
New England	25	13	12	—	—
Middle Atlantic	21	1	7	8	2
Middle West	60	33	22	2	3
South	19	18	1	—	—
West	19	11	7	—	1
Territory	1	—	—	1	—

TABLE IV  
AGENCIES IN THE SAMPLE BY SCHOOL NURSING ACTIVITIES

Types of school nursing	All agencies in sample	Reporting this activity	Reporting no activity in this field	No answer to question
Nursing service in public schools	600	360	165	75
Nursing service in parochial schools	600	197	272	131
Nursing service in nursery schools	600	101	304	195
Nursing service in private schools	600	34	337	229

Ten participated in public school nursing, 9 in parochial school work, 4 in nursery schools, and 1 in private school work. Six provided specialized nursing service for school work, and seven carried it as part of their generalized program.

Four of the 10 doing public school work reported payment directly for this work; 2 of the 9 doing parochial school work received payment; none of the 4 received payment for the nursery school work, and the 1 that worked in a private school stated it was not paid.

The title of this review is "Similarities and Variations in Programs." After these paragraphs about school nursing, a table of the four kinds of agencies active in the two major kinds of school nursing may bring to focus the similarities throughout the country. Of the 168 health departments, 79 reported service to both public and parochial schools. Of the 205 boards of education, 49 reported both services. Of the 210 non-official agencies, 11 reported both services. Of the 17 combination agencies, 6 reported both services.

The schedules used to gather the information contained seven pages of schedule and three pages of instructions. The 600 replies represent a real contribution to the study of public health nursing, and the N.O.P.H.N. is appreciative of the time and patience involved.

In tabulating the replies, however, there were some unclassifiable answers—even many staring blanks. It is usually believed that the number of unanswered questions indicate either a reflection on

the skill of the wording of the questions or a lack of interest by those filling them in. The number of "no statements" to be tabulated takes away from the value of a study. Table IV shows the replies about the four kinds of school work from the 600 agencies. It is curious to see that 75 agencies left questions about public school work without answers; 131 left questions about parochial school work unanswered; 195 passed over the nursery school section; and 229 showed little interest in private school nursing.

#### ORTHOPEDIC NURSING

The previous discussion shows that school nursing is being done by agencies of all kinds. This is also true of orthopedic work in public health nursing agencies, although only 23.3 percent of the 600 agencies replied that they had an orthopedic program. Among the health departments in the sample, 36.9 percent reported orthopedic programs, and among the nonofficial agencies, 26.7 percent reported this type of work. Of the 17 combination agencies, 9 reported orthopedic programs. Among the boards of education, 13 reported the employment of specialized nurses for orthopedic work.

Considering orthopedic work in public health nursing by geographical areas, we find that agencies in the Southern and Midwestern states are more likely to include orthopedic work than are agencies in other areas. There were 31.9 percent in the Southern and 30.3 percent in the Midwestern states reporting orthopedic work. Only 8.9 percent

TABLE V  
ORTHOPEDIC NURSING IN PUBLIC HEALTH NURSING AGENCIES BY GEOGRAPHICAL AREAS

By geographical areas	Total agencies in sample	By replies about orthopedic nursing			
		Reporting orthopedic nursing service		Reporting no orthopedic nursing service	No reply about orthopedic nursing service
		Number	Percent		
Total, all areas	600	140	23.3	440	20
New England	123	11	8.9	108	4
Middle Atlantic	124	28	22.6	95	1
Middle West	188	57	30.3	124	7
South	94	30	31.9	59	5
West	70	14	20.0	53	3
Territory	1	—	—	1	—

of the agencies in New England states reported orthopedic nursing.

The fact that there is a decided interest in orthopedic nursing is indicated by the few failures to reply to the section on this subject. Only 20 of the 600 agencies in the sample failed to answer in some way, a far better showing of interest than was noted in the review for school work.

Of the 140 agencies reporting an orthopedic program, 55 employed specialized orthopedic workers. Such employment was more usual in nonofficial agencies than in official. The Midwestern

states (12 states make up this area) are most likely to have specialized personnel, since of the 57 agencies in this area, 31 reported specialized orthopedic workers, a higher proportion than in any other area.

Studying in still more detail the orthopedic personnel of these agencies we find that only 15 employed supervisors particularly for orthopedic work. The location of these 15 emphasizes again the interest in orthopedic work in the Middle West.

The concentration of orthopedic work in public health nursing in the Middle

#### AGENCIES EMPLOYING ORTHOPEDIC SUPERVISORS IN THE YEARLY REVIEW SAMPLE

State	City	Name
New England		
Massachusetts	Boston	Community Health Association
Middle Atlantic		
New York	Brooklyn	Visiting Nurse Association of Brooklyn
Pennsylvania	Erie	Visiting Nurse Association
Pennsylvania	Reading	Visiting Nurse Association
Pennsylvania	York	Visiting Nurse Association
Middle West		
Illinois	Chicago	The Visiting Nurse Association of Chicago
Illinois	Evanston	Visiting Nurse Association of Evanston
Indiana	Indianapolis	Indianapolis Public Health Nursing Association
Iowa	Des Moines	Public Health Nursing Association
Kansas	Kansas City	Visiting Nurse Association
Missouri	Kansas City	Visiting Nurse Association of Kansas City
Nebraska	Omaha	The Visiting Nurse Association of Omaha
Wisconsin	Milwaukee	The Visiting Nurse Association
South		
District of Columbia	Washington	Bureau of Public Health Nursing of the Health Department
Louisiana	Shreveport	Caddo-Shreveport Health Unit



Western area is an interesting state of affairs, and guesses have been made as to reasons for this interest. Have there been more infantile paralysis patients there? Has the work of earlier leaders in public health nursing kept the need before the agencies? According to the 1940 report of "Hospital Service According to Types of Service and Agencies Concerned,"\* there were only 14 orthopedic hospitals in these Midwestern states, as compared with 26 hospitals in the Middle Atlantic states and 30 in the Southern. The number of beds in these orthopedic hospitals were: Midwestern states, 1322 beds; Middle Atlantic, 3247 beds; Southern, 1848 beds. In the Middle West the ratio of population to beds in orthopedic hospitals is more than 30,000 persons per bed—the highest in the five areas. While general hospitals also serve some orthopedic patients, long-time care is less frequent in them than in the special orthopedic hospitals. It would seem, therefore, that possibly home services of nurses are more necessary in the Middle West than in areas with more numerous beds in orthopedic hospitals.

#### INDUSTRIAL WORK

Industrial work was less frequently part of the public health nursing program than was orthopedic nursing. No health department and no board of education reported nursing personnel for industrial health work. Of the 210 non-official agencies, only 27 reported special service to industrial workers. Of these, 8 reported specialized service, and only 2 in the entire sample employed specialized industrial supervisors. These 2 agencies were both in Pennsylvania—The Visiting Nurse Society of Philadelphia and The Public Health Nursing Association of Pittsburgh, Pa.

\*American Medical Association, Council on Medical Education and Hospitals. "Hospital Service According to Types of Service and Agencies Concerned." *The Journal of American Medical Association*, March 15, 1941, pages 1071-1144.

Of the 17 combination agencies, 4 reported special service to industrial workers. These services were given by generalized staff nurses.

Of the 227 agencies included in the nonofficial and combination agencies in the sample, 31, or 13.7 percent, reported industrial health work; 176 stated they did not do industrial health work; and 20 left the question blank.

Industrial nursing among the agencies seemed more usual in the Middle Atlantic states and Middle West than in other areas. Twenty-one of the 116 agencies in these areas, or 18.1 percent, reported such work.

It is surprising to know that some of the smaller agencies are doing industrial health work. Of the 31 agencies reporting industrial work, 15 employed less than 10 nurses; 10 employed from 10 to 49 nurses; and only 6 employed more than 50 nurses.

Sixteen of the 31 agencies gave service in the factory. The others reported home visits only.

None of the 31 agencies stated that they were not paid for the work in industries, but only 28 gave the actual sums received for the year. These varied from \$2 to \$3700. Payment was on the visit basis in many instances.

The increasing interest in industrial health work prompted further review of the industrial programs in these agencies and among others that did not send in Yearly Review schedules. This was reported in the December issue of *PUBLIC HEALTH NURSING*.\*\* The supplying of part-time nursing service to industry and commerce is an interesting way of making the most use of available public health nursing facilities.

Follow-up for other agencies was more frequently a part of the programs in nonofficial agencies than was school nursing, orthopedic work, or industrial

\*\*Houlton, Ruth. "Contracts for Industrial Nursing Service." *PUBLIC HEALTH NURSING*, December 1941, p. 735.

nursing. Among the 210 nonofficial agencies, 94 reported follow-up for other agencies, and among the 17 combination agencies, 8 reported such work. Only 37 of the 227 were sufficiently uninterested in this question to leave it blank.

Hospital follow-up was most frequently mentioned. Clinics and dispensaries also made use of the visiting nurse frequently for home visits. Case-work agencies appeared in the lists in some cities. In some instances, the non-official and combination agencies did follow-up work for health departments.

One agency listed 12 agencies for which it did follow-up work. Four were hospitals, four local health departments, and one each a clinic, a tuberculosis county welfare board, a crippled children's commission, and an American Red Cross chapter. Another visiting nurse association listed 7 agencies, of which 4 were hospitals, 2 were case-work agencies, and 1 a reformatory. Cancer and tuberculosis hospitals frequently use the visiting nurse for follow-up work.

Only 9 visiting nurse associations listed more than 5 organizations for which they did follow-up work. Twenty-nine visiting nurse associations named only one with whom they cooperated in this way; of these, 23 were hospitals.

Only 7 agencies stated that they received payment for follow-up. Payment varied from \$6 to \$3500, the latter sum for work done for patients who had been in the county tuberculosis sanatorium. One large agency received \$150 a month from one general hospital, \$6 a patient from a maternity clinic for postpartum care, and \$135 on a visit basis from a case-work agency.

So far as geographical areas are concerned, the agencies in the Middle At-

lantic states and in the West seem to do follow-up for other agencies more frequently than do visiting nurse associations in other sections. In the Middle Western states only one quarter of those sending in Yearly Reviews reported follow-up, whereas in the Middle Atlantic and Western states, more than half reported these services.

The larger visiting nurse associations assist in follow-up for other agencies to a greater extent than do the smaller ones. Among the 227 agencies studied for follow-up services, 102, or 44.9 percent, replied that this was part of their programs. Among the agencies employing 50 and more nurses, two thirds included follow-up work. Among the agencies employing 10 to 49 nurses, about one half did this. And among the agencies employing less than 10 nurses, only one third reported follow-up work. This distribution by size of agency is what one would expect.

#### CONCLUSION

These discussions of similarities and variations in programs in public health nursing seem to show that there is no one type of agency that has a monopoly on any one kind of program. Programs appear to have developed as needs and appeals for them became apparent. The work seems to have been done by the agency able to meet these needs. There are obvious similarities in the programs of the four types of agencies, but it is the variations that make this kind of study so interesting. Further information is available and lists of agencies active in these fields may be borrowed from the National Organization for Public Health Nursing, 1790 Broadway, New York, New York.

## News from the S.O.P.H.N.'s

**T**HE *Texas S.O.P.H.N. News Letter* came as a result of a felt need. The 260 public health nurses and lay members who make up the organization are scattered all over Texas. Many are unable to attend all the meetings and without some means of communication they know little of the workings of their own State Organization for Public Health Nursing. The Board of Directors decided 18 months ago that a news letter to the members would keep them in touch with the program and policies of the organization. One objective has been to keep it a bulletin of the S.O.P.H.N. and not any particular health agency in the state.

Six issues of this quarterly bulletin, mimeographed on long blue sheets of paper, have been mailed to the member-

ship. Since the news letter was a new venture and one for which no one was especially prepared, it has been prepared jointly by the president and the secretary, with material submitted by the chairmen of the standing committees and the various sections. It is sent out by the secretary, who is responsible for the mimeographing and preparation for mailing. The expense, which is negligible, is borne by the Organization. Stencils, paper, envelopes, and a permit for the use of 1c pre-cancelled stamps for mailing comprise the total cost. The secretary has been able to secure volunteer help for most of the clerical assistance needed.

FAYE PANNELL, R.N.

*Secretary-Treasurer, Texas State  
Organization for Public Health Nursing*

**T**wo hundred people attended the Minnesota S.O.P.H.N. spring meeting, held in May at the time of the annual nurses' institute and State Conference of Social Work.

The S.O.P.H.N. initiated a bill for state aid to county nursing services which was sponsored by the Minnesota Department of the American Legion. The chairman of the Lay Section was especially active in securing the support of the county nursing committees and other interested lay people in working for this important legislation. The S.O.P.H.N. is indebted to the Minnesota Nurses' Association for providing a legislative worker who watched the progress of the bill after it was introduced. Although the bill did not pass this year, we feel that the efforts made were well worth while because they created interest and a more intelligent understanding of the need for some type of state sub-

sidy for public health nursing in order to place it on a more permanent basis.

Forty nurses attended the Industrial Nursing Section's first institute for industrial nurses this year. The S.O.P.H.N. was especially pleased to secure D. Irene Bigler, industrial nursing consultant of the National Organization for Public Health Nursing, to speak at one of the meetings, and to be available for conferences with individual nurses.

The Board of Directors in July asked the History Committee to get in touch with the director of the Minnesota Writers' Project of the Works Progress Administration regarding a project to cover the writing of the history of public health nursing in Minnesota. The request was approved by the WPA. Space, desk, and typewriter are supplied by the Division of Public Health Nursing of the

*(Continued on page 125)*

# Defense of the Nation's Health

## SUBCOMMITTEE PERSONNEL

**M**ARION G. HOWELL, dean of the Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland, Ohio, has been appointed chairman of the Subcommittee on Nursing of the Health and Medical Committee, Office of Defense Health and Welfare Services, to succeed Mary Beard.

Miss Howell was formerly professor of public health nursing and director of the University Public Health Nursing District of Western Reserve University. Since 1933 she has been dean of the School of Nursing; and in 1939 the program in public health nursing was transferred to the School of Nursing, so that now all nursing courses at Western Reserve University are coordinated under Miss Howell's direction.

Miss Howell is well known to public health nurses throughout the country as first vice-president of the National Organization for Public Health Nursing.

Miss Beard, former chairman of the Subcommittee, resigned because of the growing burden of responsibility placed upon her as director of the American Red Cross Nursing Service.

Marion W. Sheahan, director of the Division of Public Health Nursing in the New York State Department of Health, has been appointed to fill the vacancy on the Subcommittee created by Miss Howell's elevation to the chairmanship.

Miss Sheahan is a member of the Executive Committee and the Board of Directors of the National Organization for Public Health Nursing. She is a member of the Committee on Administrative Practice of the American Public Health Association; and chairman of its Subcommittee on Nursing, which is identical with the Committee on Nurs-

ing Administration of the N.O.P.H.N.

The position of executive secretary of the Subcommittee on Nursing, which has been held by Alma C. Haupt since July 1, 1941, has been put under United States Civil Service classification as "chief nursing consultant" by an executive order of January 1, 1942. This establishes the position for the duration of the emergency.

The Metropolitan Life Insurance Company, which lent Miss Haupt to the Subcommittee last July, has extended the loan of her service to July 1, 1942.

Edith H. Smith, a Pacific Coast nurse who was formerly professor of nursing and director of the nursing service at Stanford University Hospitals, has been appointed assistant executive secretary to the Subcommittee. Miss Smith has had broad educational and administrative experience in this country and abroad. She was assistant in the Nursing Division, League of Red Cross Societies, in Paris from 1924 to 1931. She has been active in California professional nursing organizations and will bring an understanding of the nursing problems and resources of the West Coast to her new position.

## LOCAL NURSING COUNCILS

**L**OCAL NURSING COUNCILS on defense, representing local nursing groups and organizations, are being formed throughout the country. The following suggestions are offered by the U. S. Office of Civilian Defense for effective use of nursing resources by local councils:

1. Consult with your local chief of emergency medical service regarding plans for the use of local nursing resources.
2. Arrange for meetings of the nursing profession at which the local chief of emergency medical service may explain the emergency

plans. It is especially important that public health nurses be thoroughly instructed so that they may carry information to the public.

3. File with the chief of emergency medical service an inventory of available nurses, with their location and telephone number both day and night. Duplicate files for sections of the city are advisable in large metropolitan areas. Additional information on these cards, stating the type of work each nurse is doing and the name of the organization in which she is employed, will assist in assigning nurses to various phases of emergency duty. If the nurse has been assigned to a hospital field unit, this should be specified on her card.

4. Consult with the local chief of emergency medical service about plans for additional service that may be needed in homes. For example:

a. If it is necessary to provide hospital beds for the care of casualties, patients may be discharged from hospitals earlier than usual. It may be advisable to have such patients visited in their homes by public health nurses.

b. Following an "incident," the physician at the scene decides whether slightly injured persons may be sent home after first-aid treatment is given. Some of these patients may well be visited in their homes by public health nurses before they report to a clinic or elsewhere for a final check. The resources of all agencies using public health nurses could be pooled for this service so as to provide care in each section of a city and avoid duplication.

5. Keep your state nursing council informed concerning your local activities and problems.

These suggestions are excerpted from materials being transmitted from the U. S. Office of Civilian Defense through state defense councils to state nursing councils on defense.

A plan for participation of nursing service in the local emergency service program is described in the following publications\* issued by the OCD:

Emergency Medical Service for Civilian Defense, Medical Division Bulletin No. 1.

Equipment and Operation of Emergency Medical Field Units, Medical Division Bulletin No. 2.

Other publications\* of the OCD are:

Training Courses for Civilian Protection

A Civilian Defense Volunteer Office

Civilian Protection—How to Organize It in Your Community

\*These publications may be obtained from state or local defense councils or from the regional office of the OCD.

Enrolled Volunteer Worker Groups for Civilian Protection  
Volunteers in Health  
Medical Care and Nursing

#### STATE NURSING COUNCILS

NURSING COUNCILS on defense have been set up in 45 states and in the District of Columbia and Puerto Rico. Through these state councils the Nursing Council on National Defense, the Subcommittee on Nursing of the Health and Medical Committee, Office of Defense Health and Welfare Services, and the Medical Division of the U. S. Office of Civilian Defense hope to coördinate the defense efforts which concern the nursing profession. The profession is in a very strategic position during this emergency, and only by united effort can it meet the challenge to procure, educate, and assign the nurses needed by our country at the present time. While some of the councils are still in the process of organizing, the response to calls for help from national headquarters has been immediate and heartening.

The state organizations are endeavoring to form a working alliance with state defense councils, so that two types of responsibilities may be met by the nursing councils:

Close coöperation with the state defense council in planning for emergency programs for civilian protection, such as local assistance in emergency medical units, participation in Red Cross activities, and dissemination of information.

Emergency and long-range planning which is professional in character, in which nursing leadership is necessary, such as plans for recruitment of student and graduate nurses and expansion of educational facilities.

Recruiting of student nurses is going on apace. Each state nursing council has formulated plans to reach down into its smallest community. New impetus has been given to the ever-present task of finding well qualified applicants for good schools of nursing to meet the government's call for 50,000 students.

Other programs will be carried on as



the various national groups furnishing leadership put their plans into effect through the state nursing councils.

Following is the list of states that have nursing councils on defense, together with the secretaries who have so far been appointed:

- Alabama**  
Mrs. Walter Bragg Smith, 625 South Lawrence Street, Montgomery
- Arkansas**  
(To be announced)
- Arizona**  
Minnie C. Benson, 1620 Hedrick Drive, Tucson
- California**  
Shirley C. Titus, 609 Sutter Street, San Francisco
- Colorado**  
Mary Walker, 621 Majestic Building, Denver
- Connecticut**  
Elizabeth G. Fox, 35 Elm Street, New Haven
- Delaware**  
Mrs. Mildred A. Marshall, 914 Jefferson Street, Wilmington
- District of Columbia**  
Edith Beattie, 1746 K Street, Northwest, Washington
- Florida**  
Mrs. Phyllis R. Leonard, P. O. Box 1007, St. Augustine
- Georgia**  
Mrs. Esther Watts, 3304 Fourteenth Avenue, Columbus
- Idaho**  
Mary C. Chapman, St. Luke's Hospital, Boise
- Illinois**  
J. Olive Seger, 512 Willoughby Tower, 8 South Michigan Avenue, Chicago
- Indiana**  
Helen Teal, 1125 Circle Tower, Indianapolis
- Iowa**  
Alma E. Hartz, State Department of Health, Des Moines
- Kansas**  
Mrs. Anne Lee Wick, 359 North Clifton Avenue, Wichita
- Kentucky**  
Mrs. Myrtle C. Applegate, 604 South Third Street, Louisville
- Louisiana**  
Graham Price, Baptist Hospital, Alexandria
- Maine**  
Mrs. Alice S. Hawes, 54 Saunders Street, Portland
- Maryland**  
Hester K. Frederick, 1217 Cathedral Street, Baltimore
- Massachusetts**  
Helene G. Lee, 420 Boylston Street, Boston
- Michigan**  
Thelma Scratch, Visiting Nurse Association, 51 West Warren Avenue, Detroit
- Minnesota**  
Caroline Rankiellour, 2642 University Avenue, St. Paul
- Mississippi**  
Mrs. Julia Blue, 3209 Twenty-fourth Avenue, Meridian
- Missouri**  
(To be announced)
- Montana**  
Florence Whipple, State Health Department, Helena
- Nebraska**  
Mrs. Avis Purdy Scholder, Clarkson Hospital, Omaha
- Nevada**  
Reta Grant, 339 West First Street, Reno
- New Hampshire**  
Mrs. Minnie T. Wilder, Elliott Hospital, Keene
- New Jersey**  
Wilkie Hughes, 17 Academy Street, Newark
- New Mexico**  
Mrs. Fannie T. Warncke, State Department of Public Health, Box 711, Santa Fe
- New York**  
Emily J. Hicks, 152 Washington Avenue, Albany
- North Carolina**  
Mrs. Marie B. Noell, 415 Commercial Building, Raleigh
- North Dakota**  
Clara G. Lewis, State Capitol, Bismarck
- Ohio**  
(To be announced)
- Oklahoma**  
Grace Westrope, 1109 Northeast 17 Street, Oklahoma City
- Oregon**  
Mrs. Linnie Laird, 301 Stevens Building, Portland
- Pennsylvania**  
Mrs. Katharine Miller, 400 North Third Street, Harrisburg
- Rhode Island**  
Louise White, 42 Weybosset Street, Providence
- South Carolina**  
Nellie C. Cunningham, 306 Carolina Life Building, Columbia
- South Dakota**  
Mrs. Opal Sandbeck, City Health Department, Sioux Falls
- Tennessee**  
Gladys M. Piper, Department of Health, Nashville
- Texas**  
A. Louise Dietrich, 1001 East Nevada Street, El Paso
- Utah**  
Dorothy Chamberlain, 130 State Capitol Building, Salt Lake City
- Vermont**  
Mrs. Abbie Starkey, 3 Nelson Street, Montpelier
- Virginia**  
Mrs. Jessie Wetzel Faris, 811 Grace-American Building, Richmond
- Washington**  
Marian G. Kent, 1110 Textile Tower, Seattle
- West Virginia**  
May M. Maloney, 47 Capital City Building, Charleston
- Wisconsin**  
Leila I. Given, Room 353, State Office Building, Wilson Street, Madison
- Wyoming**  
Louise M. Gray, Natrona Memorial Hospital, Casper
- Puerto Rico**  
Celia Guzman, Duffant No. 22, Santurce

# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

## BIENNIAL ASSISTANT APPOINTED



On January 5, Evelyn C. Nelson came to the N.O.P.H.N. for a six-months' period to serve as assistant for the Biennial Convention which is to be

held in Chicago, Illinois, May 17 to 22. Miss Nelson's coming will help to bridge the gap left by the resignation of Anna C. Gring on January 1 to become educational assistant in home nursing in the American Red Cross.

Miss Nelson is a graduate of the school of nursing of the University of Minnesota, from which she has her B.S. degree and a certificate in public health nursing. She attended the summer session of the Smith College School for Social Work in 1936, taking courses in psychiatric social work. Miss Nelson brings to the N.O.P.H.N. a background of urban and rural experience in both nonofficial and official agencies. She has held positions as staff nurse, assistant supervisor, and supervisor in the Community Health Service in Minneapolis, and as supervising nurse in the Maternity Demonstration, Wexford County Department of Health, Cadillac, Mich.

## TRANSPORTATION CHAIRMEN

Information about railway transportation to the Biennial Convention in Chicago, May 17-22, may be secured from the chairman of the transportation committee in your state. In many states the secretary or executive secretary of the state nurses' association serves also as chairman of the committee on transportation. The complete list of chairmen follows:

Arizona—Minnie Benson, 1620 Hedrick Drive, Tucson

Arkansas—\*Mrs. Mary T. Wright, 5404 T Street, Little Rock

California—Harriott L. P. Friend, 609 Sutter Street, San Francisco

Colorado—\*Irene Murchison, 621 Majestic Building, Denver

Connecticut—\*Margaret K. Stack, 252 Asylum Street, Hartford

Delaware—\*Mrs. Mildred A. Marshall, 914 Jefferson Street, Wilmington

District of Columbia—\*Edith M. Beattie, 1746 K Street, Northwest, Washington

Florida—\*Mrs. Phyllis R. Leonard, P.O. Box 1007, St. Augustine

Georgia—\*Durice Dickerson, 131 Forrest Avenue Northeast, Atlanta

Idaho—\*\*Annie Laurie Crawford, State Hospital South, Blackfoot

\* Executive secretary, state nurses' association

\*\* Secretary, state nurses' association

\*\*\* General secretary, state nurses' association

- Illinois—\*Charlotte F. Landt, 1014 Willoughby Tower, Chicago
- Indiana—\*Helen Teal, Circle Tower, Indianapolis
- Kansas—\*\*Mrs. Anne Lee Wick, 359 North Clifton Avenue, Wichita
- Kentucky—\*Mrs. Myrtle C. Applegate, 604 South Third Street, Louisville
- Louisiana—Henrietta Brink, 2502 Pine Street, New Orleans
- Maryland—\*Mrs. Blanche G. Powell, 1217 Cathedral Street, Baltimore
- Massachusetts—\*Helene G. Lee, 420 Boylston Street, Boston
- Michigan—\*Olive Sewell, Capitol Savings and Loan Building, Room 212, Lansing
- Minnesota—\*\*\*Caroline M. Rankiellour, 2642 University Avenue, St. Paul
- Mississippi—\*\*Ruth Steen, Delta State Teachers College, Cleveland
- Montana—\*Anna T. Beckwith, Box 928, Helena
- Nebraska—Halcie M. Boyer, 626 Electric Building, Omaha
- New Hampshire—\*\*Dorothy Heath, 8 Copp Street, Nashua
- New Jersey—\*Wilkie Hughes, 17 Academy Street, Newark
- New Mexico—Pearl Dillon, 322 South Stanford, Albuquerque
- New York—Emily J. Hicks, 152 Washington Avenue, Albany
- North Carolina—\*Mrs. Marie B. Noell, 415 Commercial Building, Raleigh
- North Dakota—Mrs. Edna Schneider, 1118 Avenue C, Bismarck
- Ohio—\*\*\*Mrs. Elizabeth P. August, 50 East Broad Street, Columbus
- Oregon—\*Mrs. Linnie Laird, 301 Stevens Building, Portland
- Pennsylvania—\*\*\*Mrs. Katherine Miller, 400 North Third Street, Harrisburg
- Rhode Island—\*Louise White, 42 Weybosset Street, Providence
- South Carolina—\*Nellie C. Cunningham, 306 Carolina Life Building, Columbia
- South Dakota—Carrie Benham, Mitchell
- Tennessee—Nina Wootton, 1002 Cotton State Building, Nashville
- Texas—\*A. Louise Dietrich, 1001 East Nevada, El Paso
- Utah—Ada Burt, 2120 South Tenth East, Salt Lake City
- Vermont—\*Mrs. Abbie L. Starkey, 3 Nelson Street, Montpelier
- Virginia—\*Mrs. Jessie W. Faris, 811 Grace American Building, Richmond
- Washington—\*Marian Kent, 1110 Textile Tower, Seattle
- West Virginia—\*May M. Maloney, Capital City Building, Charleston
- Wisconsin—\*Mrs. C. D. Partridge, 3727 East Layton Avenue, Cudahy
- Wyoming—Mrs. Elinor Nottage, 314 East 26 Street, Cheyenne

## LAY BIENNIAL REPRESENTATIVES

Board and committee members who are going to the Biennial Convention will be glad to know that in each state they have a Biennial representative who will tell them about the special plans and program for board members at the Convention. A list of appointments so far received is published here. Names of representatives in the other states were not received in time for publication, but may be obtained by writing to the National Organization for Public Health Nursing, 1790 Broadway, New York, N.Y.

- Alabama—Mrs. Clifford Lamar, 3000 Dundee Circle, Birmingham
- Arizona—Mrs. J. D. Hamer, 1819 North 11 Avenue, Phoenix

- Connecticut—Mrs. Louis L. Coudert, 83 Kenyon Street, Hartford
- Georgia—Mrs. J. Randolph Tobias, 18 West Harris Street, Savannah
- Kentucky—S. L. Greenebaum, Jr., Kentucky Home Life Building, Louisville
- Maine—Mrs. Langdon Thaxter, 100 Neal Street, Portland
- Minnesota—Mrs. Stuart W. Rider, 224 Groveland Avenue, Minneapolis
- Mississippi—Mrs. Clifford Lamar, 3000 Dundee Circle, Birmingham, Alabama
- New Jersey—Mrs. Murray Rushmore, 971 Kensington Avenue, Plainfield
- New Mexico—Dr. Estella Ford Warner, District Medical Director, U. S. Department of the Interior, P.O. Box 527, Albuquerque
- New York (Metropolitan District and Long Island only)—Mrs. Charles S. Brown, 133 East 80 Street, New York
- North Dakota—Mrs. Stuart W. Rider, 224 Groveland Avenue, Minneapolis, Minnesota

Ohio—Mrs. R. Livingston Ireland, 19100 North Park Boulevard, Shaker Heights, Cleveland  
Rhode Island—Mrs. Austin T. Levy, Harrisville

South Carolina—Mrs. J. Randolph Tobias, 18 West Harris Street, Savannah, Georgia

South Dakota—Mrs. Stuart W. Rider, 224 Groveland Avenue, Minneapolis, Minnesota

Tennessee—Mrs. Arch Trawick, 2501 Ashwood Avenue, Nashville

Utah—Mrs. Frank W. Penrose, 230 South 9 Street East, Salt Lake City

Washington—Mrs. Dietrich Schmitz, 4400 Beach Drive, Seattle

West Virginia—Mrs. Victor Shaw, 425 Morgantown Avenue, Fairmount

Wisconsin—Mrs. Stanley Stone, 2015 East Glendale Avenue, Milwaukee

#### MISS BUTLER APPOINTED

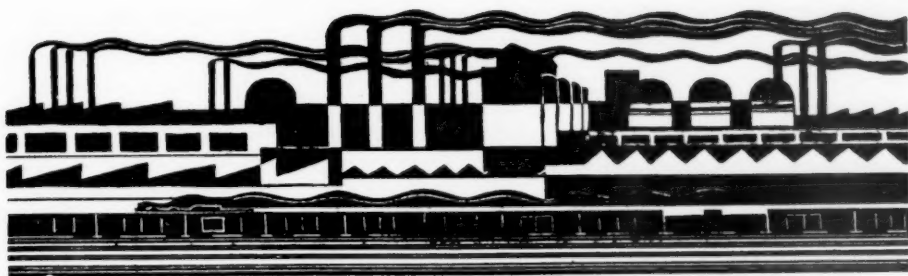
Ida F. Butler, formerly director of the American Red Cross Nursing Service, has been appointed convention manager for the 1942 Biennial Convention. Miss Butler served as manager for the last Biennial in Philadelphia.

#### PUBLICATIONS COMMITTEE MEETS

The policies of the magazine under wartime conditions were considered by the Publications Committee at its annual dinner meeting in New York City on January 21. The Committee recommended that news on defense as it relates to public health nurses be given priority. However, since the nursing care and health supervision of the civilian population are of vital importance in wartime, public health nurses will continue to need help through the magazine on all types of health problems and nursing services. The Committee agreed that more careful selection of material will be necessary both in regard to quality and to priority needs. It recommended that the special column, "Defense of the Nation's Health," be discontinued and that the short news items on defense activities be incorporated into the regular news section.

Famous Michigan Boulevard, as seen here from the Bridge with the Tribune Tower to the right and the Wrigley "twins" on the left, will be a familiar scene to Biennial Convention visitors during week of May 17-22.





## What Can the Industrial Nurse Accomplish?

By PAULINE E. KUEHLER, R.N.

**I**NDUSTRIAL nursing today is a definite, specialized branch of the nursing profession. It is a far cry from the early years when the nurse, on entering an industry, had to grope her way through the unexplored field of industrial medicine and nursing.

The hospital background does not prepare the nurse to meet the responsibilities and problems of a present-day industrial medical service. A nurse entering an industry today should have a fair knowledge of the basic principles of industrial medicine and nursing. She is expected to be efficient and expert in analyzing and treating injuries. She must know what to do as well as what not to do; must have some understanding of human behavior; must be diplomatic and a sympathetic and patient listener to real and fancied grievances, without passing judgment. She must be ready to give help on health, social, and family problems. She must often assume the duties of laboratory, physical therapy, and x-ray technicians.

Opportunities for special training are still limited. However, a study of psychology, industrial hygiene and toxicology, industrial compensation laws, and industrial and community health problems should be considered an essential

part of the nurse's preparation for industrial service.

Industrial nursing is a broad term and may include one or more types of service carried on by a nurse. She may be engaged in regular community nursing, but because of lack of community resources, may receive her compensation from an industry. She may be a visiting nurse but limit her service to employees of an industry. She may limit her services to strictly clinical duties within the industry, as in a situation where an industry employs a large medical and clerical staff. She may render a comprehensive nursing service within the industry under the direction of either a part-time or full-time physician—which is the kind of industrial nursing to be discussed here. The duties and opportunities of a nurse in such a service are manifold.

1. She must have a thorough understanding of the problems involved in the care of injured employees and be able to distinguish between so-called minor injuries and complaints and potentially serious injuries or illness.

2. She must be able to cooperate intelligently with management, safety and personnel engineers, and supervisors.



3. She must be familiar with the hazards peculiar to her industry and be able to recognize pathological symptoms that may be associated with such hazards.

4. She must keep accurate and complete records of injuries and illnesses.

5. She must maintain the first-aid room or dispensary on an efficient and economical basis.

6. She must be able to adjust herself to the community in which her industry is located and find her place in the public health, social, and recreational program of that community.

#### MUST KNOW RESOURCES

On entering an industry, the nurse should find out why she was employed, what medical and consultant services are available for her to use, and what is the scope of service she is expected to render to the employees of that industry. If the industry already has a medical service, her relationship and responsibilities to this service should be definitely established.

She should ascertain what safety and welfare organizations are functioning within the industry and establish her relationship to these agencies. She should become familiar with the general setup of the industry, the number of employees, the products, and the possible hazards in the processes of manufacturing these products. She should become acquainted with the community public health, welfare, and recreational facilities.

It is not uncommon to hear a nurse say: "I have been here several months and I don't know yet what I am supposed to do." The fact that she was employed should convince her that there was a need for her services. The management of the industry, sincere in its effort to provide nursing service, naturally expects the nurse to advise it regarding the needs and functions of her department and the services she is prepared to

render within the limits of her preparation and license to practice.

Essentially the industry is concerned with the welfare of the employee. However, it is impelled not entirely by a humanitarian interest, but by an economic motive as well. It is concerned with the reduction of loss of time and efficiency, due to injuries, illnesses, and maladjustment. The workman's compensation act has placed a definite responsibility on industries, which is measurable in dollars and cents. The success of the medical and nursing service is also measured by the financial gain to both employee and industry.

The industrial nurse can stay in her first-aid room or dispensary and at the same time render valuable service to the industry by expert and efficient treatment of injuries and by intelligent coöperation with the management, the safety engineers, and the accident- and sickness-prevention programs. To the industrial nurse every injury, no matter how superficial, is a potentially serious one. She must have a thorough understanding of the problems involved in the medical care of wounds and the so-called minor complaints. During the treatment of an injury the employee is usually willing to tell the nurse just how it happened. The alert nurse can quickly recognize potential causes of serious accidents, and this information should immediately be given to the accident-prevention department.

Coöperation with the program of the plant for prevention of accidents and industrial diseases is an important part of the nurse's work, and her opportunities are almost unlimited. By gaining the confidence and good will of the worker who comes to the dispensary "because it is the safety rule" she can convince him that safety is not just a law to be obeyed, but a safeguard to his health and welfare. The problem is no longer one of selling safety to the management of an industry, but rather of teaching it

to the worker. Safety and general health suggestions can usually be fitted into the general conversation during the employee's visit to the dispensary, and invariably he repeats to his "gang" what the doctor or the nurse said.

#### NURSE IS NOT A "PILL PEDDLER"

The industrial nurse must not become a "pill peddler"! "Give me some aspirin, I have a headache," or "I have a cold," or "Give me something for my indigestion" are requests heard daily in the industrial dispensary. To the trained industrial nurse, a headache may mean eyestrain due to defective vision or poorly fitted glasses, sinus infection, or various other pathologic conditions. "Indigestion" may be the warning signal of some impending serious gastro-intestinal or heart disease. The treatment of these so-called minor complaints definitely does not come within the scope of the nurse's work, and may also involve legal responsibility for the industry. These cases should come under the management of the family physician. Here the nurse has the opportunity to impress upon the worker the value of periodic physical examinations for himself and his family.

Symptoms such as headaches, gastro-intestinal disorders, and coughs may also be due to some hazard in the worker's occupation and may be a warning of conditions that will eventually become an industrial liability. The nurse who knows her industry, the products of that industry, and possible hazards in the manufacturing processes can render a valuable service to the industry by promptly reporting any suspicious symptoms to the designated authorities for investigation.

The actual investigation of accidents by the nurse is of doubtful value, since she cannot be expected to be familiar with the details of each employee's occupation. This responsibility should belong to a designated investigator or to the department foreman or supervisor. A mutual respect for each other's job will

foster a better coöperation between foremen, supervisors, and the medical department.

Too much stress cannot be placed on the value of keeping accurate and complete records of both injuries and illnesses. Regardless of who is responsible for keeping these records, the nurse should keep informed in regard to the progress and end result of the injuries and illnesses of the employees who come under her observation. Records should be in a form that permits a quick analysis of the employee's working and general health history. A repetition of the same type of injury should be investigated, since it may be due to one or more correctable factors, such as poor vision, insufficient or improper lighting, lack of understanding of machinery, or faulty equipment. The worker whose dispensary record shows repeated complaints, such as colds, joint pains, or headaches, should have a thorough physical examination by the plant physician—if one is available for that service—or by his private physician. Too much emphasis cannot be placed on the value of a family physician.

The nurse who knows the employees of her industry and their dispensary history, and makes this information available to responsible authorities within the industry as a guide in job restriction and adjustment, is rendering a valuable service to both employees and industry. Employees who are restricted in their occupation because of systemic disorders or physical defects, such as high blood pressure, diabetes, heart disease, cataracts, or arthritis should be kept under the observation of the medical department, and any change in their condition should be called to the attention of the department supervisor.

The maintenance of the first-aid room or dispensary should be the responsibility of the nurse. A clean, orderly, and properly equipped first-aid room inspires confidence in the medical service

of an industry, and its appearance is usually an indication of the type of service rendered.

In medium-sized or smaller industries, the nurse usually has the responsibility of ordering necessary supplies, preparing surgical dressings, and supervising the sterilization of dressings, instruments, and other equipment.

#### NURSE IN SMALL COMMUNITY

When the nurse enters a small community, she automatically becomes a part of the health and welfare services of that community. Her active participation in these programs should be consistent with the public relations and industrial policies of her industry. Physical examination and injury records must be considered strictly confidential and any such information has to be cleared through authorized channels. However, the nurse should participate in conferences concerning health and family problems of an employee when these have become the responsibility of community health and social agencies. These conferences can be informal, such

as those which are held in one community where the social worker, school nurse, community nurse, and industrial nurse frequently meet during the noon-day lunch hour. Due to the present increase of government and industrial activities and the shortage of trained public health personnel, industrial medical services will have to assume a definite responsibility in the community health and welfare programs.

In contrast to the earlier days of industrial nursing, the nurse of today has the assistance of such agencies as the industrial hygiene bureau of her state or local health department, the Division of Industrial Hygiene of the U. S. Public Health Service, the National Safety Council, and other official and non-official agencies.\* By taking advantage of the service which such agencies offer and utilizing them in her daily tasks and contacts, she is helped to live up to the full meaning of the title: "industrial nurse."

\*For a list of these agencies, see "A Program for Staff Education," in the January issue of PUBLIC HEALTH NURSING, page 39.

### EXHIBIT AND FILM ON SYPHILIS

**A**N EXHIBIT of eight charts showing how syphilis and gonorrhea threaten young men in military service and workers in industry has been prepared by the American Social Hygiene Association. The full sized posters, 17" by 22", are available for \$1 a set unmounted; \$3 a set mounted. In miniature, 8½" by 11", they are available for 10 cents a set. A flier reproducing the posters in miniature is available from the Association upon request.

A new one-reel talking motion picture, "Plain Facts About Syphilis and Gonorrhea," has been prepared by the Asso-

ciation for industrial and community groups. The picture is a documentary film with voice and sound throughout. It is an excellent educational film for groups of industrial workers. The running time is 10 to 12 minutes. The picture is available in 35 mm. or 16 mm. film at a rental of \$5 a day besides transportation charges. The 16 mm. film can be secured for review without charge except for postage. The films can also be purchased. For information write to the American Social Hygiene Association, 1790 Broadway, New York, New York.



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EDITED BY ANNA C. GRING

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#### POPULAR BOOKS ON NUTRITION

*America's Nutrition Primer.* By Eleanor Sence. 95 pp. M. Barrows and Company, New York, 1941. \$1.

*We Need Vitamins.* By Walter H. Eddy, Ph.D., and Gessner G. Hawley. 102 pp. Reinhold Publishing Corporation, New York, 1941. \$1.50.

The author of *America's Nutrition Primer* has covered the subject of "What to Eat and Why" in eight brief chapters, and packed each paragraph with helpful facts, simply and interestingly stated. The meal plans and recipes in the last two chapters round out the information that the average reader wants on this subject.

There will be some who think her suggestions for protein foods too high, and it is true that the amounts could not be purchased on an economical budget. It is unfortunate, too, that there are errors in her vitamin and mineral chart, notably those on milk and evaporated milk, which should show the same values in a table such as this.

However, there is so much material in the book that is of practical help that it is one to recommend.

Though prepared for the general reader, *We Need Vitamins* gives so many nonessential details about the various vitamins that it will probably confuse, rather than help him. The average reader probably does not care about the number of hydrogen, oxygen, and carbon atoms in each vitamin, nor

about the many factors in the B complex which are still little known even to the research chemist.

Readers are interested in the vitamin content of food, but the tables giving this information are printed in such small type that they are difficult to read.

There are several other popular books on vitamins which laymen will find much more helpful than this one.

LILLIAN ANDERSON  
New York, New York

#### INDUSTRIAL HYGIENE AND OCCUPATIONAL DISEASES

Course Outline and Digest of Lectures Given in Cooperation with the National Conservation Bureau. Center for Safety Education, Division of General Education, New York University, New York, 1941. (Mimeographed.) \$1.25.

The field of industrial hygiene has developed rapidly in the past decade. It is a highly specialized field, and the many problems relating to the industrial poisons and other health hazards require for their solution the use of techniques with which only the specialist in the field is ordinarily familiar.

A number of excellent textbooks dealing with various phases of industrial hygiene have appeared, but these are of interest chiefly to the specialist. For others, no single volume has been published which presents in elementary form the essentials of the whole industrial health problem. For this reason,

the present volume is of particular interest. It was prepared especially for a group who are not technical specialists in the field but whose work nevertheless brings them into direct contact with the problems of control of industrial health hazards.

The volume consists of fifteen lectures, prepared by well known authorities, and includes discussions of dusts, metallic poisons, toxic gases and solvents, industrial dermatoses, methods of air sampling, and control of industrial health hazards by ventilation and personal protective equipment. The general medical problem and legal phases of the industrial health problem are also considered. The several lectures are well presented in a systematic manner. Included is an extensive general bibliography and special bibliographies in connection with certain chapters.

THEODORE HATCH  
*Philadelphia, Pennsylvania*

#### OBSTETRICS FOR NURSES

By Joseph B. DeLee, M.D., and Mabel C. Carmon, R.N. 651 pp. W. B. Saunders Company, Philadelphia, twelfth edition revised, 1941. \$3.

This text contains many examples of improvised equipment and procedures that will be found useful in the home, although it is written primarily for hospital service.

The nursing instruction throughout is good. Of particular value to public health nurses are the chapters on Care During Labor at Home, Care During the Puerperium, and Care of the Child.

Dr. DeLee emphasizes the importance of meticulous, safe care as given by the nurse and the attendant. A spirit of understanding of and sympathy for the parturient pervades all of his writing, and the development of a refined technique for surrounding her with all the safeguards known is emphasized throughout. A nurse could scarcely fail to develop an obstetrical conscience after careful study of this material on

nursing procedures. Throughout the book the nurse's role as a nurse and her numerous duties are made to seem quite as important as those of the obstetrician.

This is a well illustrated textbook for the student nurse. For the public health nurse, with her needs for a broader and more thorough knowledge of anatomy and pathology, Dr. Lee's *Principles and Practice of Obstetrics* might be more helpful.

ELIZABETH R. FERGUSON, R.N.  
*Baltimore, Maryland*

#### THE PREMATURE INFANT

By Julius H. Hess, M.D., and Evelyn C. Lundeen, R.N. 309 pp. J. B. Lippincott Company, Philadelphia, 1941. \$3.50.

This is the most comprehensive text on the subject of medical and nursing care of the premature infant that has yet come to the reviewer's attention. In the preface the authors express the conviction that for the welfare of the premature baby there is no substitute for "untiring, unremitting care." For that reason they have combined in their book discussions of the medical and nursing phases of this care.

The etiological, developmental, functional, and pathological aspects of prematurity in babies are presented as a background for comprehending the rationale of therapeutic measures as well as the routine techniques in the care of these babies.

The chapter on home care and that on city and state plans for the care of the premature infant cannot fail to be of particular interest to the public health worker.

The method employed by the authors of following the discussion of each aspect of medical care with a description of the nursing care associated with it is effective in bringing about continuity.

The material is derived largely from the authors' experience and from techniques and procedures in use in the care



of the premature infant at the Sarah Morris Hospital Station and in other health agencies in Chicago. Nevertheless, the book will undoubtedly prove to be an invaluable source of information and guidance to medical and nursing students and to physicians and nurses in hospitals and public health agencies in other cities.

HORTENSE HILBERT, R.N.  
*Washington, D. C.*

#### SIMPLIFIED NURSING

By Florence Dakin, R.N., and Ella M. Thompson, R.N. 444 pp. J. B. Lippincott Company, Philadelphia, fourth edition, 1941. \$2.

In this day of almost constant discussion of how to meet the large burden being placed on nursing, it is encouraging to find a new textbook that will aid in the training of the subsidiary worker or so-called practical nurse. This book of three parts begins with an introduction which contains the objectives of the course, together with discussions on admission requirements, length of the course, placement, supervision, and licensure, all of which will be useful to the instructor.

In Part One, personal and public health are discussed with a simplicity that should appeal to the untrained worker. The underlining of the few technical words used in the chapter on anatomy and physiology is a clever device to assist the learner in acquiring a small but necessary scientific vocabulary. The pictures and illustrations are clear and numerous.

Part Two includes nursing procedures which are explained and illustrated in a simple manner. The last two chapters, dealing with first aid and common emergencies, are disappointing. Since so much emphasis is being placed on this instruction for laymen as a defense measure, it is regrettable to find the material in these chapters for the most part out of date and not following the methods suggested by the American Red Cross text. The numerous pictures

dealing with the complicated methods of roller bandages seem quite out of place in a book for the nonprofessional nurse. Since scouts and lay groups have been taught for years the many uses of the triangular bandage, it would seem that this information might have been included. Since there is an inexpensive text on first aid, the reviewer feels that these two chapters might well have been omitted.

In the section on Practical Nursing in Special Conditions are good discussions on the problems and diseases affecting the aged and chronically ill, and the health of the mother-to-be, the infant, and the child.

This book comes at a time when it will be useful to many, and a welcome addition to the rather meager supply of books in this field.

ELIZABETH CURTIS, R.N.  
*Trenton, New Jersey*

#### A DIABETIC MANUAL

By Elliott P. Joslin, M.D. 238 pp. Lea and Febiger, Philadelphia, seventh edition revised 1941. \$2.

The seventh edition, thoroughly revised, of the Joslin manual of diabetes presents in simple and concise language the experience of its author and his many patients accumulated throughout the years. While written primarily for the patient, it is of real value to the physician. Its 59 questions and answers for diabetic patients should be helpful to nurses and social workers. Clear explanations are given of the complications which may arise in the care of the diabetic, as well as of diets, insulin, daily exercise, and general routine care.

Having used all former editions, the reviewer is again impressed with the amount of important and valuable information contained in this slim volume, which brings to us the most recent advances in the treatment of diabetes.

RUSSELL RICHARDSON, M.D.  
*Philadelphia, Pennsylvania*

**PSYCHIATRIC NURSING**

By Katharine McLean Steele, R.N. 390 pp. F. A. Davis Company, Philadelphia, fourth edition, 1941. \$3.50.

Although written primarily for the student nurse, this book is a useful reference for the public health nurse. Factors that enter into the psychopathic personality and various psychoses are described through the case-study method. The book includes a presentation of the recent methods of treating the psychoses. One chapter is devoted to the treatment and nursing care of schizophrenia. A.C.G.

**HANDBOOK OF COMMUNICABLE DISEASES**

By Franklin H. Top, M.D. 682 pp. The C. V. Mosby Company, St. Louis, 1941. \$7.50.

It is difficult to write without exaggeration of the great merits of this admirable volume. The author has built upon his unusual opportunities and experience as clinician, hospital director, epidemiologist, health administrator, and teacher of doctors, nurses, and health officers, to describe the phenomena and control of the whole list of notifiable diseases likely to be encountered in continental United States.

This is a handbook that can be recom-

mended without reservation to all concerned with the care of the sick and with the control of communicable diseases as authoritative, accurate, well expressed, and well illustrated. There is no other book of equal scope in this field that represents so adequately present-day fact and opinion.

HAVEN EMERSON, M.D.  
*New York, New York*

**A PRIMER ON THE PREVENTION OF DEFORMITY IN CHILDHOOD**

By Richard B. Raney, M.D., in collaboration with Alfred Rives Shands, Jr., M.D. 188 pp. National Society for Crippled Children in the United States of America, Inc., Elyria, Ohio, 1941. \$1.

This small book describes briefly and simply in nontechnical terms the deformities which may accompany the afflictions of childhood. It is written to assist social workers, teachers, and public health nurses in the prevention and early recognition of such deformities. Dr. Raney states in the preface "... that those who first see the affected children should possess a knowledge of preventive treatment." The suggestions given are practical, specific, clear, and concise.

MARY MACDONALD, R.N.  
*New York, New York*

**RECENT PUBLICATIONS AND CURRENT PERIODICALS****GENERAL**

**IN THE TEENS.** Edwina A. Cowan, Ph.D. John Hancock Mutual Life Insurance Company, Boston, 1941. 24 pp. Limited quantities free.

This is an understandable pamphlet directed to the parents of girls and boys from 12 to 20.

**RURAL REGIONS OF THE UNITED STATES.** A. R. Mangus, United States Government Printing Office, Washington, D. C., 1940. 230 pp. Free.

The report of a study in which the United States is divided into geographical regions within which social and economic conditions are relatively uniform and among which there

are significant differences. A descriptive map showing these areas is also available. The study will be of particular interest to administrators and rural nurses.

**AN INTRODUCTION TO MEDICAL SCIENCE.** William Boyd, M.D. Lea & Febiger, Philadelphia, second edition revised, 1941. 358 pp. \$3.50.

**REFERENCE HANDBOOK FOR NURSES.** Amanda K. Beck and Lyla M. Olson. W. B. Saunders and Company, Philadelphia, ninth edition revised 1941. 347 pp. \$1.60.

This new and completely revised edition will be welcomed by nurses employed in all types of nursing. Among the additions are the chapter devoted to a discussion of professional

standards in nursing, a brief description of the function of the three national nursing organizations, and the names and addresses of the various government nursing services.

**INTRODUCTION TO PATHOLOGY.** C. Russell Salisbury, M.D. The Macmillan Company, New York, second edition revised 1941. 439 pp. \$2.50.

A reference book which public health nurses will find useful. The language is nontechnical and the explanations clear and concise.

**THE 1941 YEAR BOOK OF PUBLIC HEALTH.** J. C. Geiger, M.D. The Year Book Publishers, Chicago, 1941. 544 pp. \$3.

#### INDUSTRIAL

**INDUSTRIAL HEALTH PRACTICES.** National Association of Manufacturers, New York, 1941. 76 pp. For further information write to publisher.

This report gives specific information for evaluating health programs, prevailing policies, and the annual per capita cost of such services.

#### DIABETES

**DIABETES MELLITUS.** Department of Educational Nursing of the Community Service Society, 105 East 22 Street, New York, 1941. 11 pp. 5c.

This useful pamphlet summarizes concisely in outline form the present authoritative information on this disease, its symptoms, diagnosis, treatment, and complications. Practical points on the administration of different types of insulin and on general hygiene and diet are included.

**A PRIMER FOR DIABETIC PATIENTS.** Russell M. Wilder, M.D. W. B. Saunders Company, Philadelphia, seventh edition revised, 1941. 184 pp. \$1.75.

This revision is brought up to date by the description of an improvement in the procedure of administering protamine-zinc insulin in combination with regular insulin. The primer will prove helpful to both nurses and patients.

#### DENTAL HEALTH

**TEETH HEALTH AND APPEARANCE.** Developed by Lon W. Morrey, D.D.S. The Bureau of Public Relations, American Dental Association, Chicago, 1940. 47 pp. \$1.50.

This book will prove especially useful to school nurses and those nurses who teach groups. The illustrations are effective, and the content is written in nontechnical style.

**COMMUNITY COMMITTEES FOR DENTAL HEALTH.** National Dental Hygiene Association, Washington, D. C., 1941. 19 pp. Free.

Public health nurses will want this pamphlet to help them in their participation in the work of the dental health committee in their own community.

**GETTING READY TO TACKLE LIFE.** American Association of Orthodontists, New York, 1940. 5c.

#### DEFENSE

**SERVICES TO THE ARMED FORCES.** The American National Red Cross, Washington, D. C., 1941. 32 pp.

This little booklet reviews the development of Red Cross service to American armed forces and describes the organization's program of today.

**HIDDEN HUNGERS IN A LAND OF PLENTY.** National Maternal and Child Health Council, Washington, D. C., 1941. 25c.

A handbook of nutrition projects for local communities—a cooperative venture of the American Association of University Women and the Council, with special assistance from the American Red Cross and the American Dietetic Association.

**PROTECTION AGAINST GAS.** United States Office of Civilian Defense, Washington, D. C., 1941.

A guide for communities in setting up an organization for protection against gas attack. It discusses the nature of chemical warfare, the different types of war gases, and their effects on the human body. This is a nontechnical reference booklet not intended for medical personnel.

**TRAINING COURSES FOR CIVILIAN PROTECTION.** United States Office of Civilian Defense, Washington, D. C., 1941.

A publication designed to aid in the organization and conduct of training courses for volunteers in civilian protection services.

**UNITED STATES CITIZENS DEFENSE CORPS.** United States Office of Civilian Defense, Washington, D. C., 1941.

Here are answers to the questions: Who can join . . . How can one join . . . and What are the qualifications for joining . . . the Citizens Defense Corps, and other pertinent data.

**OPPORTUNITIES IN NURSING.** Committee on Recruitment of Student Nurses, Nursing Council on National Defense, New York, N. Y., 1941. Free.

This three-page folder may be secured free of charge from state nursing councils on national defense.

## NEWS NOTES

• As this issue goes to press, four base hospitals, with an enrollment of over four hundred nurses, have been ordered to active duty: Base Hospital No. 4, University Hospitals, Cleveland; Base Hospital No. 5, Harvard and Peter Bent Brigham Hospital, Boston; Base Hospital No. 21, Washington University General Hospital, St. Louis; and Evacuation Hospital No. 52, Pennsylvania Hospital, Philadelphia.

• Louise Kieninger, formerly director of the University of Colorado School of Nursing, Denver, has been appointed assistant executive secretary of the Nursing Council on National Defense. Mrs. Elmira Bears Wickenden is executive secretary of the Council.

• The annual luncheon meeting of the Central Council for Nursing Education will be held on February 16 in Chicago (Grand Ballroom, Palmer House, at 12:15 p.m.) in conjunction with the Congress on Medical Education and Licensure. Franklyn Bliss Snyder, president of Northwestern University, will address the group at the meeting.

• Agnes Talcott, director of nurses, Los Angeles City Health Department, was honored by her staff at a tea in November in celebration of her twenty-fifth year of service with the Department. Miss Talcott pioneered in the development of complete public health nursing service—including bedside care—in a health department. During her period of service the Department staff grew from 29 nurses to 145. She has twice been a member of the Board of Directors of the National Organization for Public Health Nursing and was first president of the California State Organization for Public Health Nursing.

• Ruth C. Waterbury, group nursing assistant of the Nursing Bureau, Metropolitan Life Insurance Company, has retired after 17 years of service with the organization. In the Company's announcement of her resignation, tribute is paid to her contribution both to the field of industrial nursing and to the organization's welfare program. Bernadine Striegel, territorial supervisor of the M.L.I. Southwestern territory, is appointed as Miss Waterbury's successor.

• Seven scholarship awards for study in orthopedic nursing were made by the Joint Committee on Orthopedic Scholarships at its meeting on December 15. These scholarships were made possible by a grant to the National League of Nursing Education from the National Foundation for Infantile Paralysis.

1. Helen Bearden, head nurse, Children's Hospital, Denver, Colorado

2. Lulu Boswell, head nurse at Tuskegee Institute, Tuskegee, Alabama

3. Marjorie Gould, supervisor in orthopedic department at Children's Hospital, Iowa University Hospitals, Iowa City, Iowa.

4. Emma Jean Hill, surgical supervisor at Newton Hospital, Newton Lower Falls, Massachusetts

5. Hildred Holland, Shriners' Hospital in San Francisco, California

6. Kathleen Newton, graduate student at Teachers College, New York, New York

7. Dorothy Pratt, orthopedic supervisor at Boston Children's Hospital, Boston, Massachusetts

### NEW APPOINTMENTS

(For N.P.S. appointments, see page 77)

The United States Public Health Service announces the following 26 appointments to the National Institute of Health at Bethesda, Maryland, for the orientation program:

#### *Assistant public health nursing consultants*

Zella Bryant, Mrs. Anna E. Love, Celia Moore, Helen Ronayne.

#### *Public health staff nurses*

Patience Carr, M. Margaret Casey, Lucille Corcoran, Catharine M. Eyster, Mary L. Folley, Mrs. Josephine D. Gaines, Margaret P.

Judd, Marjorie Kennedy, Anna M. Matter, Hildure Nelson, Muriel Schopp, Lucile A. Wilcox, Mrs. Doris B. Wright.

*Junior public health staff nurses*

Ethel Elfenbein, Dorothy I. Fowler, Gesine Anna Franke, Marjorie L. Gaston, Mary E. Jenkins, Alfreda A. Luedtke, Mrs. Inez B. Matthews, Mrs. Rona Whelan, Bertha M. Zagers.

These assignments have been made by the Public Health Service to state health departments:

*Public health staff nurses*

Dorothy F. Johnston, Oklahoma; Muriel K. Morrow, Maryland; Genevieve T. Piette, Nebraska; Alida L. Warner, Oklahoma.

Appointments to United States Public Health Service districts for assignment to states are:

*Assistant public health nursing consultant*

Mrs. Mildred G. Eslick, District IV, New Orleans, Louisiana.

*Public health staff nurses*

Hazel Barkley, District I, New York, New York; Agnes Butoryak, District III, Chicago, Illinois; Mary A. Collins, District III; Mrs. Alma B. Harvey and Ruth Henton, District VII, Kansas City, Missouri; Mary K. Marta, Sub-District IV, San Antonio, Texas.

*Junior public health staff nurses*

Mary E. McConnel, District V, San Francisco, California; Jean Martin, District IV.

### News from S.O.P.H.N.'s

(Continued from page 108)

Minnesota Department of Health, and the history is now being written.

The Education Committee has been instrumental in carrying out some of the plans started in previous years. Arrangements were made with the educational director of nursing education in the State of Minnesota to schedule observations of nursing activities requested by public health nurses in the Minneapolis General Hospital and the University Hospital, and also observations by faculty members of schools of nursing in the two local public health nursing agencies. Nurses from both fields took advantage of these opportunities.

Discussion classes were arranged for faculty members of the twin cities' schools of nursing who had taken the

course in principles of public health nursing the preceding spring and who were conducting the public health course for senior classes of schools of nursing. These classes were paid for by the S.O.P.H.N.

The two meetings of the S.O.P.H.N. Education Committee were conducted jointly with the Education Committee of the Minnesota State League of Nursing Education.

The General Secretary of the Minnesota Nurses' Association represents the State Organization for Public Health Nursing on the subcommittee of health on the Committee of Health and Welfare Services of the State Defense Council. In several counties, county nurses have already been asked to serve on local defense councils.

ANN S. NYQUIST, R.N.

*President, State Organization  
for Public Health Nursing*

(N.P.S. continued from page 77)

greatly needed sympathetic guidance and tangible aid such as only the profession could offer when jobs were at a premium. From this early beginning in a borrowed office with a half-time director and a half-time clerk, the Service has gone forward, passing through changing periods of the country's economic status—depression, recession, and now a synthetic prosperity. The shortage of nurses, as everyone knows, is acute, and N.P.S. must search assiduously since standards continue to be high.

Our place in the national defense program is clearly defined. And N.P.S. will keep the home fires burning so that when the time of demobilization of large numbers of nurses arrives and work is again scarce, nurses will have their own agency which operates everywhere, ready for them, with a strong organization skilled in vocational guidance and placement techniques to aid them.

ANNA L. TITTMAN, R.N.

*Executive Director*



# Our Readers Say . . .

## DELIVERING A BABY IN AFRICA

EDITOR'S NOTE: This letter from a nurse in Africa is published through the courtesy of the Maternity Center Division of the Visiting Nurse Association of Brooklyn, New York, to which it was sent:

As I have only been in Africa three months, I haven't seen a lot of the native life, but you might be interested in the first native delivery I saw. I had only been here a few days when we were asked to get a woman out in a native "kraal" who was having a miscarriage. When we arrived, we discovered the child was full term and the mother wanted to come into our dispensary.

We had gone twenty miles in the truck, or lorry, as they are called here. Then we had a ten-minute walk through the bush to find the mother. As soon as I saw her I thought, "This delivery room is very much air-conditioned." The mother was sitting under a chicken coop. The floor of the coop was perhaps five and one-half feet from the ground, with a thatched roof. It was supported on a dozen poles. On one side a reed mat had been hung to protect the woman from the bright rays of the sun.

The delivery table was the ground. It was littered with straw, which had been scratched from the chicken coop. The "sterile linen" consisted of a tight string tied about the waist to prevent the child from going up instead of down. The bedding was an old, dirty blanket which had seen much use since being washed. The native midwives, or "mbuya," were as much unclothed as the mother, although some of them wore old skirts and one or two had very old waists.

While some of the men were making a stretcher to carry the mother to the truck, one of the women brought out a clean dress for her to wear. Amid all the rest of the dirt, it looked very much out of place.

One thing I didn't notice at the time but have learned since is that the midwives fill the rectum with mud to prevent the child from coming through the rectum.

We had gone about half-way home when we stopped for the delivery. The baby weighed almost eight pounds and was as healthy as could be. If it had been delivered where we found the mother, the cord would have been cut between two stones and tied with chewed strips of bark.

Someone has said that the native infant mortality here in Rhodesia is fifty percent. Do you wonder? The mothers are coming to us more and more. Last year forty came to our dispensary to have their babies. A doctor visits us once a month, and after the first of March I will be the only white nurse here on the mission, and it is fifty miles to a hospital or doctor.

VIOLA MABIE, R.N.

*Mutambara Mission*

*Umtali, Southern Rhodesia, Africa*

## THINKS NEW BOOK VALUABLE

Almost in the same mail with our requested review of Marguerite Wales' book, *The Public Health Nurse in Action* (January issue, page 57) we received this letter. Since it presents a somewhat different angle in regard to the book's usefulness we are publishing it here. [Ed.]

This book is so valuable to me that I had to express my appreciation for such a volume. I like it especially because it helps the nurse in the rural areas. How much more valuable it is to her, with its excellent example of good work, than is a study that shows all the bad points in a home visit and leaves no pattern for comparison. A nurse not under close supervision needs this guidance.

This book will be welcomed by public health nurses everywhere. The principles of nursing administration are democratic and based upon sound educational procedures. The ultimate aim of public health nursing is ever to be of better service to the patient, the family, and the community. The wealth of material presented by the author is clear and meaningful.

The book should prove an invaluable aid in discussion groups, such as staff-education conferences. In the light of recent studies of the field visit, the book should be a well-spring of information and inspiration.

MARIE C. BUCKLEY, R.N.

*Chicago, Illinois*

## FROM SOUTH DAKOTA

I wish to take this opportunity to express my appreciation for the PUBLIC HEALTH NURSING magazine. I refer to it so often and don't know how I could do without it.

ANNA M. BLACK, R.N.

*Public Schools  
Rapid City, South Dakota*

# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## Public Health Nursing in Time of War

**S**AFEGUARDING high professional standards and stretching public health nursing resources to their utmost to meet the needs of the emergency are not necessarily incompatible objectives. Whether the second entails a sacrifice of the first depends on how intelligently we plan and act both on a community scale and within the individual agency. It depends upon our willingness to consider immediately and objectively all possibilities of realignments and readjustments that will make for greater productivity within the community and within the agency, regardless of how unorthodox and even radical such changes may appear.

Public health nursing has arrived at the stage in its development where future progress lies chiefly in the quality of service; and the preservation and improvement of professional standards essential to a high quality of nursing care are of first importance. On the other hand we realize that contemporary conditions call for a determination to develop as never before a mobility and flexibility within the profession that will enable public health nurses to meet as adequately as possible the requirements of the military and civilian population.

The importance of civilian health in the emergency is emphasized in a recent declaration published by the American Public Health Association:

Any neglect or curtailment of the essential protection of civilian health, whether at home or in the factory or other work place, is inconsistent with maximum efficiency of the military forces.

The trained civil health worker is properly

considered indispensable to the maintenance of national health, and he should be encouraged to continue at his regular station in civil government unless it becomes perfectly clear that the war can be more effectively prosecuted by his transfer to military service.\*

Public health nurses as trained civil health workers employed either by governmental or non-governmental health agencies contribute extensively to the "essential protection of civil health" and are also in a position to be called for military service.

A national crisis makes unusual demands upon the professional and personal disciplines inherent in nursing—disciplines that the public has with justification come to expect from us in an emergency.

Like other professions, public health nursing is at the moment concerned primarily with making its particular type of social effort count for as much as possible toward a victorious outcome of the war. Like other workers, public health nurses as individuals want to serve in the way in which they will contribute most toward the maintenance of the health of civilians and armed forces alike.

To do the best we can to help maintain essential health services and health education; to help the families we serve keep up morale, by doing our part toward the relief of tensions; to give families an understanding of the use of

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\*A declaration of the American Public Health Association on public health in the emergency, American Public Health Association Year Book, 1941-1942, a supplement to the *American Journal of Public Health*, March 1942.

community facilities for care during illness and for preventive health services—these are our continuing functions in war as in peace. In addition, public health nurses can take on special citizen responsibilities of interpreting to families the protective facilities that are developed in a community as a part of civilian defense.

Now, if ever, all communities are faced with the absolute necessity for reviewing their public health nursing resources honestly and without prejudice, with an eye to merging and pooling such resources wherever possible for the good of the total population; with an eye to the joint utilization of public health nursing executives, supervisors, and educators, so that some of these personnel can be released to other communities where their leadership is badly needed; with an eye to simplifying each agency's mechanism so as to spread the services of its professional personnel to the fullest. The validity of the standard recommended in the *Survey of Public*

*Health Nursing* is now more than ever apparent: that "all public health nursing services be carried by as few agencies [in a community] as possible"—preferably not more than two agencies, one official and one nonofficial.

Now, if ever, is the time to perfect techniques of inter-agency coöperation; to broaden the scope of service of every public health nurse regardless of present agency affiliation or traditional limitations of agency responsibility; to supplement services of professionally trained personnel with those that can be given by volunteers and other auxiliary nursing groups.

Who knows but that a thoroughgoing examination of organizational structure and administration of public health nursing services within communities and individual agencies, necessitated by war, may reveal more productive methods that have application not only now—when economy and immediacy are imperative—but also in the time of reconstruction to come?

H. H.

### MEMBERSHIP HELPS MORALE

ONE of the less tangible but nevertheless important benefits of membership in the National Organization for Public Health Nursing is the feeling of our staff nurses that they are members of a great national organization. I think that is important to their morale—especially for those nurses who are working in isolated districts where courage and morale are essentials to their carrying on.

The pamphlets, articles on timely topics, suggestions for exhibits, and

other helpful materials which are available upon request have helped us all. It is satisfying to know that there is some organization to which we can turn when we need specific information on some subject relative to public health nursing. We can always depend on the N.O.P.H.N. to get us that information quickly and we know it will be reliable information.

CHRISTIE A. THOMPSON, R.N.  
*Supervisory Nurse, State Department  
of Health, Reno, Nevada*

# The Citizen's Role in Public Health

By CARL E. BUCK, DR.P.H.

Lay participation in public health development is essential so that the people will understand and support an effective health department program in their area

**M**ANY AND GREAT as are the needs in the field of public health, none is perhaps more important than the need for more widespread and more effective lay participation. Some might challenge this statement on the ground that scientific knowledge and sound, progressive administrative procedures are basic to public health improvement, and that without them lay participation is of little avail. Without contradicting the truth of this statement one may still maintain that the need for more active lay interest is one of the most important needs in public health; for while scientific knowledge and effective administrative procedures are progressing steadily, widespread, intelligent lay interest lags far behind. There are notable isolated examples of very effective lay participation in public health development, but for the most part lay interest has been spasmodic and often poorly directed or at least directed into relatively unprofitable channels.

It is a commonplace statement that scientific knowledge concerning disease prevention and health promotion is far ahead of its practical application. Great strides have been made in the reduction of tuberculosis, in the fight against syphilis, and in the reduction of such communicable diseases as typhoid fever, smallpox, diphtheria, plague, and cholera. But the possible goal, even with respect to these diseases, is far from being achieved.

If the goal toward which we are striving in public health is the universal understanding, acceptance, and practice of established procedures in disease prevention and health promotion, then indeed lay participation constitutes the basis for success. If all people throughout the length and breadth of this country did understand, accept, and practice known scientific procedures, syphilis would represent but a small problem as compared to its present importance, tuberculosis would be still further reduced, and typhoid fever, smallpox, and diphtheria would be practically non-existent. Notwithstanding the splendid progress which has been made, many mothers still die needlessly in childbirth, thousands of infants die who need not have died, syphilis is still widespread among us, thousands of cases of tuberculosis are not discovered until they are far advanced, and people continue to have and to die from typhoid fever, smallpox, and diphtheria. All of this is happening because not enough people know enough about these conditions to act intelligently to prevent them.

## GOOD HEALTH DEPARTMENT IS BASIC

Another point is of real importance. For years public health workers, from the Surgeon General of the Public Health Service to the part-time health officer of the smallest community, have bewailed the fact that funds for public health have been quite inadequate to accomplish even the definite results

which can be predicted. The previous reference to inadequately guided efforts of lay interest in public health points to the fact that a broad basic principle of lay health education, namely, the need for strong, adequately developed health departments has been largely overlooked. Not infrequently health officers, but perhaps more frequently public health nurses, have been notably successful in bringing about a very real interest in and understanding of certain phases of the program such as child health, tuberculosis control, syphilis control, or perhaps adequate milk supervision. Such efforts are of course highly commendable, but frequently they have overlooked the important fact that these programs in which the people have become interested are dependent for their success largely upon progressive, well staffed health departments. The old saying that "you cannot see the forest because of the trees" is nowhere more pertinent than in a situation of this kind.

It is not uncommon to find a person who waxes enthusiastic about the local tuberculosis control program or perhaps about the splendid malaria program which his community is carrying on. Yet in response to a question concerning his local health department he shows no interest and may even say that he sees no reason for supporting the health department. He fails to see any connection between the health department and the special program in which he takes such pride. He does not understand that a sound, progressive health department must always be the spearhead of any continuously effective public health program.

Efforts to obtain lay backing for specific phases of public health development have frequently been successful. The leader in the field of developing lay participation in public health has unquestionably been the public health nurse. Special credit should go to the

National Organization for Public Health Nursing for notably successful efforts in developing lay committees with truly effective participation in public health nursing activities. In my opinion public health nursing in the last twenty years has shown greater progress than any other major phase of public health, and in making this statement I am not unmindful of the splendid progress which public health engineering has made during this period.

These few words of appreciation for what public health nursing has done and is doing for public health are not made solely for the purpose of paying a compliment but especially to throw out a challenge to the health officers. What the public health nurses have done and are doing the health officers can and should do.

#### PROGRESS DEPENDS ON LAY SUPPORT

In general the health officers, with a few exceptions, have not made nearly as comprehensive and effective use of lay interest and participation as should be possible. That this is true is evidenced by two important facts:

1. While noteworthy progress has been made recently in the development of full-time local health departments, particularly since the passage of the Social Security Act, there are still many counties, cities, and other political subdivisions of this country without full-time health services. Many of these units could and would have full-time health departments if the people living in them understood their value.

2. Many political subdivisions which do have full-time health departments are supporting their departments quite inadequately because the people who live in them do not know that a few additional cents per capita would pay big dividends in terms of lives saved and sickness prevented.

The Social Security Act has conferred upon the people of the United States



many important blessings. It has also done something to us, which is our own fault. We are failing to take our proper responsibility for the development of our own local resources. Local health officers today, particularly in rural areas, are all too apt to accept the budgets prepared for them without making any real effort to increase local appropriations. With the exception of very poor areas, which will probably have to have increasingly larger proportions of their budgets supplied through outside funds, the further development of local health protection and health promotion services will have to depend upon increased local appropriations. These in turn will depend largely upon the efforts of the health officer and his staff. A comprehensive job well done is of course basic to obtaining increased local appropriations, but it will not automatically result in increased funds for the health department. The people of the area must understand that the work of their health department is of real and lasting benefit to them. They should become convinced—if the health situation of the area justifies the claim—that a few more dollars spent on public health will produce tangible results in terms of lives saved and sickness prevented.

#### PROFESSIONAL GUIDANCE ESSENTIAL

Why is there this lack of widespread, intelligent lay interest and participation in public health development? It certainly is not the fault of the people themselves. It is not the fault of the public health nurse for she has probably done more effective health education work than any other professional group. The fault seems to lie definitely at the door of the health officer. Of course, there are a number of individual health officers and health agencies such as health councils, health committees, and public health associations which have developed effective lay participation in public health, but the number

represents only a small fraction of the total number of health officers.

Why has the average health officer failed in this most important function? There would appear to be two principal reasons:

1. Most health officers do not know enough about health education to develop active lay interest. All too frequently the health officer thinks of health education as being synonymous with publicity, newspaper stories, and perhaps the radio, with an occasional lecture usually given in a style which is either uninteresting or unintelligible to the lay audience.

2. Some health officers are afraid of lay organization. Not knowing how to use lay groups, they fear to encourage these groups lest they dominate the health program in a way which will not make the most effective use of available funds and resources. Such an attitude constitutes a frank admission of inability to guide and lead.

These statements may seem unjustifiably critical of the health officer. Yet they are not so much a criticism of the health officer as of the schools of public health. One would seem justified in concluding from the activities and attitudes of the average health officer—with perhaps an occasional exception—that our schools of public health do not teach health education in the broad sense of that term. The prospective health officer does not learn much about community organization and how to make effective use of community resources. He or she—and today there are a considerable number of successful women health officers—has not learned that the press, radio, and mechanical media for health education do not constitute ends in themselves, but rather means to an end. These methods of health education do not of themselves result in effective lay action but they do prepare the individual for the reception of the personal medium.

Successful lay participation in public health depends upon effective professional guidance. It is obvious that the citizen—the lay group—must be furnished with accurate and pertinent information on public health problems, on what is being done to solve them, and on what can be done. This information and guidance—guidance particularly in differentiating between important and relatively less significant problems—must come from the health officer or from professionally trained personnel in health councils or other public health associations, or both.

#### LAY GROUPS GET RESULTS

With this professional guidance lay groups can be and have demonstrated their ability to be extraordinarily successful in such accomplishments as:

1. Bringing about the establishment of full-time local health departments.
2. Preventing professionally qualified personnel from being removed from office for purely political reasons. To do this obviously requires an understanding of the professional qualifications for various types of public health positions.
3. Obtaining reasonably adequate appropriations for full-time local health departments.
4. Developing a widespread understanding of local health problems and what can be done to solve them.
5. Carrying on a lay health education program which does result in the understanding, acceptance, and practice of established procedures in disease prevention and health promotion.

There is one emergency function which can be performed by lay groups without professional leadership. They can have removed from office an unqualified, ineffectual health officer and can insist upon the appointment of a qualified health officer.

Several points should be borne in mind in planning lay participation in the

development of public health programs.

1. The lay group or groups must have effective lay leadership. It is often advisable to have a chairman and co-chairman—usually one a man, the other a woman. It is extremely important that such chairmen and co-chairmen be free from any political bias. They should be chosen not because they represent some special group or organization but because they are prominent citizens whose opinions are respected.

2. The lay group should be an entirely independent organization, quite apart from any official governmental agency. It must not be a satellite of some other organization.

3. While the group must have professional guidance, such help should be essentially in supplying accurate information and assisting the laymen to interpret that information. Guidance and not domination should be the keynote to professional aid.

4. The lay organization should develop and conduct its own program with only such professional assistance as will insure accurate basic information and correct interpretation of facts gathered. The attitude of the professional group toward lay groups should be one of eagerness to help them do a job themselves—not to do the job for them.

In estimating the potential value of lay groups to public health development one should realize that effective lay leadership can and will produce more concerted action than professional pleading can ever hope to accomplish. This is true for two reasons. The capable lay leader knows how to talk with lay people better than the professional person. The lay group has no axe to grind; it is interested only in the health and happiness of the people, while the professional person is often assumed to have a personal interest.

One of the most notable examples of lay participation is to be found in the work of the State-Wide Public Health

Committee in Florida. This organization was established less than three years ago and now has affiliated committees in each of the state's 67 counties. Organized with a nucleus of about one hundred prominent citizens, the Florida State-Wide Public Health Committee now boasts nearly 8000 members. The potentialities of such a group with effective lay leadership and intelligent

professional guidance are enormous. Public health progress in Florida during the past few years proves the value of lay participation in public health.

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Presented before the luncheon session of the National Organization for Public Health Nursing and the New Jersey State Organization for Public Health Nursing, Annual Meeting, American Public Health Association, Atlantic City, New Jersey, October 17, 1941.

## English Tots Are Match for Our Nurses

This letter by two nurses with the Red Cross-Harvard Hospital Unit comes from a nursery school for evacuated children

DEAR FRIENDS:

Here we are more or less settled in our temporary home. It is quite an impressive place. In fact, there are so many rooms you need a blueprint to find your way about. We have asked several people how many rooms there are in the house but nobody seems to know, since they never have enough spare time to count them. The place upholds the English tradition for scorning heat in the wintertime and we are turning blue by degrees. If cold noses are any indication of health, we must be frightfully fit because we're peeling the ice off our bodies most of the time despite our flannels and hot water bottles. We thought the ice age long since past, but we're learning.

We had genuine, honest-to-goodness fresh eggs this morning for breakfast. The cook is an important person to know, and we value her friendship no end.

There are 17 lusty-voiced preschool children here, in varying stages of health, and we are on duty twenty-four hours playing nurse, foster mother, teacher, and innumerable other roles. The children are all feeling well at pres-

ent and most of them should be up after tomorrow. There have been three in bed, not very sick but running an elevated temperature. It has taken all our ingenuity plus our best infant welfare psychology to keep them amused in bed.

The estate is struggling along on a skeleton staff of six servants, and they are really struggling too. There is plenty of work for that many more. The regular nursery school staff have gone off on holiday—one because the fleet is in and one because she needed a rest. There is plenty to do, with 17 baths to be given, 17 beds to be made, dishes for 17 to be washed four times a day, the washing of faces and hands and brushing of teeth, to say nothing of caring for physiological functions endless times a day.

We have already discovered that English children are a different variety from those Gesell, Aldrich, Holt, and the rest had in mind when they wrote their books. The tried and true methods just don't work. For instance, I walk in and find Raymond swinging to and fro on the curtain. I say in my best nursery school voice: "Raymond, the curtains are to cover the windows. We never swing on the curtains." To which Raymond, instead of getting down, blithely replies, "I always swing on the curtains." And he does too!

We tried the method of encouraging independence by saying: "Cyril, put on your shoes now. You are too big to have someone do it for you. A big boy like you can dress himself." This definitely did not impress Cyril, who said indignantly, "I am not a big boy. I'm a tiny little boy." How can you argue with that?

We are constantly having difficulty with terminology. In the first place, the children have such precise and impeccable English accents that we find ourselves thinking we should listen to them instead of expecting them to listen to us. When we first came they couldn't get used to our way of talking and asked embarrassing questions such as, "Why do you say bath? It's really bawth, you know." There is nothing more disconcerting than having a tiny three-year-old look up at you and make caustic comments about your pronunciation.

Also we find that we call various articles of clothing by different names. We asked one little girl to take off her shirt and she looked at us blankly. So we tried "vest" and that didn't work. After using a few more synonyms we gave up, and she said, "Do you mean my stays?" in a lofty tone. Strange that we hadn't thought of a three-and-a-half-year-old child wearing stays! We must

admit that the children have adopted some of our ways of speech instead of trying to convert us to their way entirely. Now they all say "O.K." about every five minutes. They seem fascinated by the expression.

Apparently our isolation technique has made an impression on the children. Yesterday Raymond decided to isolate one of the little girls in the bathroom, and he informed her that she was there to stay until she was cured. When we went in to rescue her we found she had fallen behind the bathtub and was caught in a mousetrap! No permanent damage was done, however.

We take turns being with the children in the playroom, taking them out for walks, et cetera. Did you ever try taking 14 small fry out for a walk? It's one way to grow old fast, as they try to take you in 14 different directions at once. The hardest part of this whole experience is leaving a warm bed time after time in the middle of the night to minister to the little cherubs' needs. However, we like the children very much, and should like to bring some home with us as souvenirs.

MARGARET MALLOY, R.N.  
and MARIE C. GOIK, R.N.

*American Red Cross-Harvard  
Field Hospital Unit  
December 1941*

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# The Rural School Child's Lunch

By CATHERINE M. LEAMY

**Rural schools in Maryland work out nutrition programs based on their own needs and resources, through the participation of all those interested in the children's health**

THE STIMULATION of interest in better nutrition for every child is one of the objectives of Maryland's state nutrition program. The program has been varied to meet the individual needs of the 23 counties—each of which presents unique problems and resources. In several counties the school lunch seemed to be one of the most effective means through which the child's nutritional status might be improved.

Since many of the elementary schools do not have a trained school-lunch supervisor and since the opportunity for consultant service by a nutritionist is limited, the nurses of the county health departments have been an important factor in the school lunch programs. Through them community interest has been stimulated, cafeteria committees have been formed, and better school lunches have resulted. The reports of several individual nurses, given in a round-table discussion on the school lunch at the Rural Nurses' Section of the Maryland State Organization for Public Health Nursing, are summarized here to show how programs are planned to meet county needs. The names of the nurses are given on page 3.

The problem in Worcester County was to create an awareness of the existing situation so that community resources could be marshalled for a school-lunch program in every school. A survey of each child's food intake for a day was made. The nurses met with their district health committees, who volunteered

to interview the children of the first four grades. Those of the other three grades filled out record forms, and the following picture resulted:

Out of 1169 records analyzed, 32.8 percent of the children had no milk; 26.5 percent had inadequate milk; and 40.7 percent had adequate milk. Fifty percent had no vegetables; 31 percent had one vegetable; 19 percent had two or more vegetables, other than potatoes. Fifty-nine percent of the children had no whole grain cereal; 41 percent had some whole grain cereal. Fifty-seven percent of the children had no fruit; 23 percent had one kind of fruit; 20 percent had two or more different kinds. Two and six tenths percent of the children had no meat or meat substitute; 97.4 percent did have meat or meat substitute.

Such a picture of the children's needs stimulated enough interest so that the county took advantage of the surplus commodity program and individual communities took the responsibility for obtaining supplementary foods.

## CLASSROOM PROJECTS ON NUTRITION

One school in Kent County was selected by the nurse for special nutrition activity because of the interest shown by its two teachers. A hot dish for the school lunch had been served each year during the winter months through the help of the parent-teacher association. The community is isolated and has seasonal employment. Although it is surrounded by dairy and grain farming,



the town children apparently know nothing of these activities. A survey which included a careful record of each child's food intake for one week showed serious deficiencies of milk, vegetables, and whole grains in the children's diet.

Classroom activities following the survey—which did much to create interest in better food habits—included the use of food models colored by the pupils and grouped to show adequate meals; the making of posters and charts to show the improvement in food selection; the cooking of whole grain cereal; the making of vegetable soup in the classroom; and the making of butter and cottage cheese. A dairy was visited. The activities around the production and handling of milk resulted in the creation of a frieze about milk. Farmers were observed growing wheat. Wheat was ground between stones. A mill was then visited, and the story of wheat incorporated in another frieze. The wheat study ended with the serving of whole wheat muffins, made with surplus commodities.

An adequate lunch was planned and served. The children participated, using new ideas about foods for the school lunch—such as oatmeal bread sandwiches with carrot-raisin filling, molasses milk, wheat date bread to replace the usual piece of cake, and prunes stuffed with peanut butter.

Posters showing comparative food values were used throughout the nutrition teaching.

#### ALL PARTICIPATE IN PROGRAM

A school in Anne Arundel County—where the cafeteria was run by a concessionaire—asked the nurse for nutrition information. She arranged a teachers' conference with the state nutritionist, who gave a brief talk to the pupils. A visit was made to the cafeteria by the nurse and the nutritionist, and possible improvements were discussed with the manager.

Through the interest aroused by the children the parents requested a parent-teacher association meeting on nutrition. The nurse not only discussed the school-lunch problem with the parents, but showed an exhibit of the relative food values of a good and poor lunch. Following the introduction of this program, the nurse made periodic visits to both the school cafeteria manager and the teachers. As new foods were introduced in the cafeteria at the nurse's suggestion, the teachers emphasized the study of the same foods in their classrooms.

The result of these contacts has been not only an increased interest in nutrition on the part of parents, teachers, and principal, but the discontinuance of the concession and the operation of the cafeteria as an integral part of the school program by a manager paid by the parent-teacher association. The food habits of the children have improved. For example, the local storekeeper reports a great increase in the demand for dark bread.

#### NEW EXPERIENCES ARE EDUCATIONAL

The presence of malnutrition was so marked in St. Mary's County that some definite means of improving the diet of the children was greatly needed. There was no school-lunch program. At a conference of the nurse, school supervisor, and state nutritionist it was decided that with the limited facilities available in the local communities, the best approach to the problem was through emphasis on nutrition teaching. Two schools of 60 pupils each were chosen as the places for beginning the program, with the plan of seeing what results could be accomplished in these schools and then extending the program to other schools.

The teachers selected the daily lunch as a starting point. The children were keenly interested in listing the foods necessary for a good lunch. Foods were brought to school, and a lunch prepared,

using wax paper and paper napkins. After this demonstration the rooms competed in the number of adequate lunches brought each day, a procedure which resulted in each child bringing at least one of the required foods. School subjects were correlated with the nutrition activities.

Certain habits were taught, such as hand-washing before lunch, covering the desk with a napkin, and attractively arranging the lunch. Correct and pleasing table manners were also encouraged. As winter came on, a plan was worked out by which the children brought to school small jars of cocoa, soup, or similar food to be heated. There were always volunteers for serving and dish-washing. This activity required certain health standards which it is believed were carried over to the home.

#### COMMITTEE ACCOMPLISHES RESULTS

The nurse and the nutritionist in Caroline County visited a cafeteria sponsored by one school, which was not satisfactory. They discussed the problem with the principal. A cafeteria com-

mittee was formed which included the school nurse, the cafeteria manager, a representative of the parent-teacher association, two teachers, and a home economics teacher.

Some of the problems presented to the committee included getting the pupils to spend money more wisely; providing lunches which furnished more nourishment at lower cost; recording, financing, and buying to better advantage; increasing patronage; encouraging pupils to try new and different foods; securing the coöperation of the pupils in regard to the work of the cafeteria.

The accomplishments of this committee were summarized at the end of the year by the principal: Adequate equipment has been supplied, new foods have been introduced to the children by putting small servings on the plates in addition to the regular menu, the increase in the sale of whole wheat bread has been most gratifying, the feeding of undernourished children has been improved by giving them free lunches, and the administration of the cafeteria has been put on a sound basis.

### KENTUCKY TO JAPAN

THIS MESSAGE addressed from the mountain folk of Kentucky to the people of Japan on December 8, 1941 appeared in *The Quarterly Bulletin* of the Frontier Nursing Service, Autumn 1941. It is published here in part:

You made a sorry mistake yesterday. God pity you. We shall not stop fighting until as a naval and military power you are finished.

We here in our inland fastnesses know that most of your people live in mountains too and are poor as we are poor. We know the pangs of your child-bearing women; we know the wants of your little children. Because your people who did not want war abdicated

their power and left the decision to the few who did, because of that you have attacked us and we will fight you to the finish. Poor things! If you had achieved freedom of speech and press you would have demanded peace. Those of you who toil to raise rice, to catch fish, to tend silkworms, those voiceless millions of you, are now stricken to the heart.

For these millions we have a message. When we have won the war, we shall be your friends. The power over you of your own ruthless men will be broken. We shall send you food, we shall buy your silk, and give you in exchange the wherewithal to rebuild your life.

# Absenteeism Follow-up by the Nurse

By ZULA A. COLQUITT, R.N.

**E**ACH of the five plants of the Pepperell Manufacturing Company is provided with a well equipped clinical center for its employees and each clinic has its own staff of doctors and nurses. Our plant, the Pepperell Mill of Opelika, Alabama, is fourth in size and the one farthest south. One plant is in Georgia, two are in Maine, and one is in Massachusetts. The company manufactures cotton textiles.

Our plant has an average of 1050 to 1100 employees. We maintain our own village in which there are 280 families, which comprise a population of between 1300 and 1400, all employees of the mill. Not all of our employees live in the village, however. A number own their own homes, or rent and commute to work. Some rent small farms and raise foodstuffs for their families. Some even do a bit of truck gardening for markets.

Only about forty of the employees in this plant are Negroes; the rest are white.

All employees at the plant have been given a physical examination. All new employees are examined, with necessary laboratory tests. Applicants are not rejected because of a positive Wassermann test but an employee whose test is found to be positive is required to take treatment. He can go to his private physician or to the clinic at the county health center.

Our setup is one which we believe meets our needs adequately. The staff is composed of two graduate nurses and one physician. The doctor carries on a private practice but has an office in the clinic building of the plant. This building is used solely for clinical purposes and is entirely separate from the plant

buildings. One nurse stays in the clinic from 8 a.m. to 5 p.m. and is on call at other hours. The other nurse does home visiting from 8 a.m. to 5 p.m. daily and on Sundays as needed. The two nurses may arrange to be on call alternate nights and week ends.

The clinic nurse gives first-aid treatment in all accidents from the mill, and the services of the doctor are available for any accident when he is needed. Injuries are dressed daily as long as is necessary. We do have lost time from accidents, but we believe that over a period of fifteen years the plant's record has been fairly good. We have had no fatalities and no permanent total disability from injury to date, although we have had partial permanent disability, such as loss of fingers.

Families of employees as well as employees themselves have access to the clinic. The clinic services include immunizations, various treatments, and dressings of wounds from non-industrial accidents.

## ABSENTEE REPORTS MADE TO NURSE

The plant has six major departments and the clinic is furnished with an absentee report of employees from each department daily. The reasons given for absence—whether illness of the employee or family illness—are reported to us and are also given to each foreman. The visiting nurse then visits the employee in his home.

The nurse's services are free but the doctor's are paid for by the individual, except in the case of an illness or accident occurring in the plant from an industrial cause. We are fortunate in having access to the county health cen-



The exterior of the new clinic at the Opelika (Alabama) Division

Employees await their turn to see the doctor in waiting room of Opelika clinic



A view of the laboratory and dressing room in Opelika clinic

Zula A. Colquitt, in charge at the Opelika clinic, dressing foot of an employee's son



ter which is one of the best in the state. This health unit is the headquarters for 13 counties and is used as a training base for physicians, nurses, and sanitation officers.

The tuberculosis diagnostic service of this health center is available for our employees. Clinics are held weekly for patients from the entire thirteen-county district. Only a few miles away there is a new fifty-bed tuberculosis hospital for care of patients at the rate of \$1 per day. Only three patients from our plant have needed hospitalization for tuberculosis. A county appropriation has been made for hospital care of tuberculosis patients, which provides part or all of the cost of hospitalization.

Our immunizations and communicable diseases are reported to the county health office and the services of doctors and nurses from the health office are available for care of communicable disease if needed.

#### INSURANCE FOR EMPLOYEES

Our plant carries hospitalization and sickness and accident insurance for its employees, and group life insurance in addition to the state liability coverage. We have had hospitalization service now for three years and have found it to be one of the most helpful services of the plant. Insurance is not compulsory but over 75 percent of the employees participate. Employees go to a private hospital which is located in the vicinity.

The clinic is headquarters for all employees' insurance transactions. We keep records of reasons for hospitalization and number of days spent in the hospital, enter all claims for disability compensation, deliver compensation checks, and keep an account of the number of days lost by the employee. We do a physical check-up when the employee returns to work.

An individual case record is kept for each employee in the clinic and the nurse doing the home visiting keeps a

daily record of her visits. Weekly reports of both clinical and visiting nursing are submitted to the executive office at the plant and also to the home office of the company in Boston.

Routine laboratory work is done at the plant clinic but the service of the state laboratory is utilized for special diagnostic procedures such as Wassermann tests and agglutination tests for undulant fever and typhoid fever. Containers for specimens for these tests are furnished by the state. The plant is sixteen years old and to date we have not had a single case of typhoid fever in the village.

#### CARE OF MATERNITY PATIENTS

Hospital deliveries of employees have increased more than 75 percent through the hospitalization plan. Primiparas are required to go to the hospital for delivery. For multiparas hospitalization is optional but most of them prefer to be delivered in the hospital, partly because they are relieved of all the pre-delivery preparations at home. Employees are permitted to work until the fourth month of pregnancy if there are no contraindications. After delivery, they may return to work after two or three months if the doctor permits. During the eight years that the medical and nursing services have been available, we have had only two maternal deaths—one patient in the eighth month of pregnancy, due to a coronary thrombosis, and one six hours after delivery, due to lung hemorrhage from tuberculosis. The patient with tuberculosis moved into the village three months before delivery and we did not succeed in getting her to follow the medical orders for complete bed rest six weeks previous to delivery.

We have a kindergarten and nursery school combined, which takes care of children from two to six years of age from 7:30 a.m. to 2:30 p.m. while their mothers are at work. These children are



under the supervision of an instructor and also have nursing supervision. They are given one well balanced meal and they have a regular sleeping period. This provision for care of young children is an aid in keeping satisfied employees and helps to prevent absenteeism.

While the nurses are careful not to infringe on the doctor's functions, they probably enter into the inner circle of the employee's life more than the doctor has time or reason for doing. Therefore, they keep in closer contact with the causes for absenteeism. In our company, industrial nursing is considered extremely important and in each of the five plants absenteeism follow-up is conducted mainly from the clinical centers by the nurses. At our plant, we are not a self-satisfied unit. We are continually on the outlook for new means by which

the employees may be aided in their work and kept in condition to stay at work as a result of health measures which may be available through the nurse's services. This is accomplished through gaining the employees' confidence, by our contact with them in the homes, and by developing a relationship in which they will feel free to go to the nurse with their problems.

Absenteeism in industry is a subject for much concern and study, and it is not the responsibility of the industrial nurse alone to cope with the situation. However, the nurse can and does play a big part in the follow-up of absentees in her particular plant.

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Presented before the Joint Session of the Industrial Hygiene and Public Health Nursing Sections, Annual Meeting, American Public Health Association, Atlantic City, New Jersey, October 15, 1941.

## IMMUNIZATION CAMPAIGN UNDER WAY

A NATIONWIDE campaign for the immunization of children has been initiated by the United States Children's Bureau as a measure of prevention of epidemic diseases which are apt to flourish under wartime conditions due to the shifting of populations. The present emergency, with the dislocations of populations which are occurring and the shortage of doctors and nurses resulting from recruitment into the armed forces makes the danger from epidemic diseases greater than in normal times.

Although opportunities for immunization have been offered to children of school age in many states, many are still not protected against diphtheria and smallpox. Children between the ages of nine months and five years are particu-

larly susceptible to these two diseases and a concerted effort should be made at this time to protect them.

The Children's Bureau on January 22 sent a letter to every state health officer requesting consideration of a campaign to insure the immunization of all children over nine months of age against diphtheria and smallpox. No definite plan for organization of such a program was outlined, since the situations in states vary and since many states are already conducting or have conducted such campaigns. Every official and non-official agency is requested to assist in this effort. The President's Child Health Day-May Day Proclamation specifically concerns itself with the accomplishment of this program by May first.



Symbolic of the Health Center's service to entire community is this nurse with bag in hand

## Savannah's New Health Center

By HELEN E. BOND, R.N.

A city which was one of the pioneers in amalgamation of public health nursing has a new health center from which emanates all its health work for the community

**D**REAMS DO come true! Our new Municipal Health Center building—a concrete symbol of the joining of hands of official and non-official agencies to develop a large-scale health program for Savannah—was completed and occupied in May 1941.

The three-story brick building, centrally located and very accessible, covers a ground space of 120 feet by 100 feet. All public health services, including public health nursing, are centered here and emanate from this building to a city population of 100,000, in addition to a county population of 20,000. Only the activities of the City Health Department are described in this article.

The building is owned and maintained by the city. The lot and the former old building which stood on this site were given to the city by a group of public-spirited citizens in order to make possible the construction of the present building

and the continuous development of community health work. Material and labor for the building were furnished by the city, in coöperation with the Work Projects Administration.

All divisions of the City-County Health Department have their headquarters in this building except the laboratory. Likewise, practically all lay organizations doing public health work in the city use the building as headquarters for their professional staffs and to house some of their activities.

Special features are a board and committee room used by organizations doing health and welfare work; a physicians' conference room; and the commodious and convenient public health nursing quarters, planned especially to fit the particular needs of this staff. The nursing service quarters contain a library and demonstration-conference room, ample storage closets, staff cloakrooms,

and large and well arranged offices for clerical and nursing staffs. The building is equipped with (luxuries to our public health nurses!) steam heat, an elevator, and a telephone switchboard. The equipment throughout is new or reconditioned and of excellent quality.

#### CITY HEALTH PROGRAM IS FOR ALL

The City Health Department carries on a broad and inclusive public health program. The health officer\* has defined the objective as "the provision of adequate health service to all citizens, not alone the indigent and underprivileged."

In addition to other activities, the city drug dispensary and all city clinics are located in the health center. Sixty-two weekly clinics are conducted in this building, and seven additional clinics are held elsewhere. The average monthly attendance for all the 69 clinics was 7912 in 1941, including 28 weekly clinics conducted by nonofficial agencies. The school dental hygiene and dental clinic program is being expanded and developed.

The nursing service is an integral part of every phase of the whole public health

program. The nursing service operates within the area of the city, and has a nursing staff of 39. The service is completely generalized except for the school nursing work, which is specialized but coöperates closely and is well integrated with the other nursing service.

The generalized visiting nursing program includes bedside care, instructive visits, and educational group work. Probably the greatest emphases in the nursing service are placed upon maternal and child hygiene, control of syphilis and gonorrhea, and school health work. An introductory program and a continuous staff education program are carried on for the nurses.

A large amount of volunteer work in clinics, motor corps, clerical jobs, and surgical dressings is done. In 1941, service given by volunteers averaged 103 hours a week.

#### AMALGAMATED NURSING SERVICE

The nursing service and certain clinics are carried on under a community organization of lay people known as The Savannah Health Center, which was organized under this name in 1920. This is an amalgamation and a corporation of 28 official and nonofficial agencies in-

\*Dr. Charles C. Hedges.



Nursing Committee meets in conference room at Municipal Health Center



Nurses enjoy spacious  
record and conference  
room at the new center

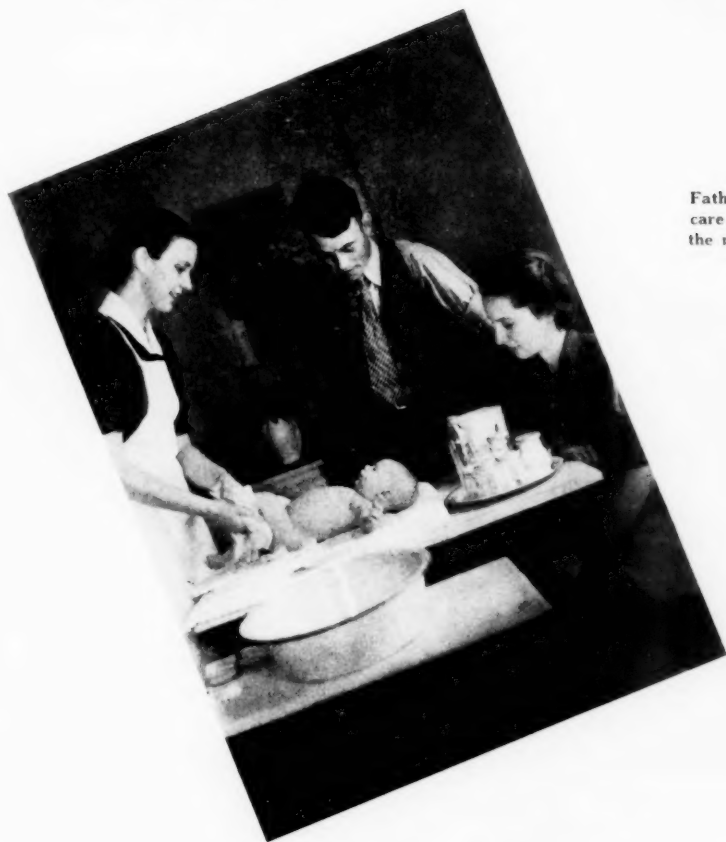
Mary becomes acquainted  
with the dentist at the  
children's dental clinic



Negro mother brings her  
three young children to  
child health conference



The health chairman of the school health committee holds a meeting



Father and mother learn care of their baby from the nurse's demonstration



terested in health work. Its early development was described in articles in this magazine in 1927 and 1929.\* The 28 agencies have pooled their resources and personnel to prevent overlapping and duplication and also to render the most efficient service possible, through one community public health program.

Cordial relations exist among all of the agencies participating in The Savannah Health Center, and all are represented on the board and on various committees. Each agency pays the cost of its own program, including salaries of personnel, in addition to a certain sum to the city for maintenance. The aid and counsel of the lay people of this organization in regard to local problems are invaluable, and the lay groups help to weave the public health work into the life of the city.

The Savannah Health Center organization is headed by a president, who is a practicing physician, and has the usual officers, board of trustees, and committees. The members are constructively interested in the whole health program of the city and they look to the health officer for guidance and leadership in all of their projects. On the other hand, their interest and financial backing are an important contribution to the entire public health program.

#### HIGHLIGHTS OF OUR GROWTH

Highlights of the development of the lay organization known as The Savannah Health Center are given here:

1903—A group of young girls, later known as the Mary Maclean Association, organized for the purpose of giving some service to the sick poor.

\*See the following articles in PUBLIC HEALTH NURSING: "The Coördinated Nursing Service of Savannah, Georgia," by Ann M. Hellner, November 1927, page 563. "The Savannah Health Center," by Helen E. Bond, November 1929, page 593.

1905—This group employed one graduate nurse to give bedside nursing care to the poor of the city. Through the years they have expanded their program and staff to the present status of a supervisor and 6 nurses, who are a part of the staff of the present amalgamated nursing service.

1910—The Mary Maclean Association established a Milk Depot to make more effective the service of its nurses to their patients.

1916—An organization, later known as the Savannah Junior League, instituted several free clinics, chiefly pediatric, and employed a small nursing staff.

1920—The Savannah Health Center was organized through the amalgamation and co-ordination of the work of the agencies mentioned above and of the Louisa Porter Home Board, with headquarters in an old building which continued to be used for some time, partly as an old ladies' home. This was on the site of the present Municipal Health Center. Other organizations joined the amalgamation.

1925—The City Health Department pooled its nursing service with that of The Savannah Health Center to carry on a common program.

1928—The County Board of Health and the Mary Maclean Association instituted a school nursing service to be conducted as a part of the Savannah health program.

1931—The Savannah Health Center became incorporated.

1937—The Chatham-Savannah Tuberculosis Association amalgamated its nursing and clinic service with that of the Health Center.

1938—The old building and lot were deeded to the city by the owners, the Louisa Porter Home Board, a lay organization.

1941—The present Municipal Health Center building was completed and the City Health Department and the agencies in the Savannah Health Center moved in and began work.

The program of activities centered within the Municipal Health Center building continues to grow day by day. Additional civic organizations continue to take up health projects and become member agencies of The Savannah Health Center lay organization. Many problems accompany growth, but they are challenging. With continuous self-analysis, and our eyes fixed always upon high goals, it is possible "to attain."

"Nursing at the Nation's Service" is the slogan of the Biennial Convention to be held in Chicago, May 18-22

# The Government's Subcommittee on Nursing

By ALMA C. HAUPT, R.N.

**A comprehensive report of the defense program of the Subcommittee on Nursing, Health and Medical Committee, Office of Defense Health and Welfare Services**

**F**OR THE SPECIAL purposes of defense and now for war, nursing has two nationwide organizations. One is governmental—the Subcommittee on Nursing of the Health and Medical Committee, operating under the Office of Defense Health and Welfare Services. (The Subcommittee also serves in an advisory capacity to the Medical Division of the Office of Civilian Defense.) The other is voluntary—the Nursing Council on National Defense, made up of the five national professional nursing organizations and the American Red Cross Nursing Service. The chief nurses of the various federal nursing services have a liaison or ex-officio relationship to both of these nationwide organizations.

The aims of both are essentially the same: (1) to analyze the country's need for the education, procurement, and assignment of professional nursing and auxiliary nursing service in relation to both military and civilian agencies relating to the national emergency (2) to make plans for meeting these needs (3) to correlate, as may be necessary, the nursing services of the United States with those of Canada, and Central and South America.

The government's Subcommittee on Nursing works with and through governmental agencies. The Nursing Council on National Defense works with and through the national professional organizations and their respective state and local constituencies. Between the Sub-

committee on Nursing and the Nursing Council on National Defense there is close and frequent interchange of information and delegation of appropriate responsibility.

Inasmuch as the Subcommittee on Nursing was formed in November 1940, this is a report of the whole life of the Subcommittee up to January 16, 1942.

On September 19, 1940, the President of the United States appointed the Health and Medical Committee which is now a part of the Office of Defense Health and Welfare Services under Paul V. McNutt, director. Dr. Irvin Abell is chairman and Dr. James A. Crabtree executive secretary of this Committee. Its location in the Office of Defense Health and Welfare Services associates its program with those of family protection, social protection, recreation, and nutrition, all closely related to the vast program of the Federal Security Agency. In fact, it is recognized that problems of health, social welfare, recreation, and nutrition are heightened by war and defense needs and therefore should be handled by an organization that fits in closely with the already existing programs of the government which consider them from the long-range standpoint. It is significant that the term "Health" as well as "Medical" is included in the title of the Committee.

The Health and Medical Committee in turn has set up subcommittees on Dentistry, Hospitals, Industrial Health

and Medicine, Medical Education, Negro Health, and Nursing. The membership of these subcommittees is made up of "experts" in the various fields rather than of organization representatives, and the appointments are made by the Health and Medical Committee.

#### ORGANIZATION OF SUBCOMMITTEE

The Subcommittee on Nursing gets its official status through the Health and Medical Committee. It was formed on November 20, 1940, with Mary Beard as chairman. (See *PUBLIC HEALTH NURSING*, December 1940, p. 767.) On December 1, 1941, Miss Beard resigned as chairman, and in January 1942, Marion G. Howell became chairman.

The Subcommittee has three special nursing education consultants, and one Special Nursing Consultant on Recruitment of Student Nurses. There are two "special" committees, one on Army and Navy Nursing, the other on the National Survey of Registered Nurses.

#### THE STAFF OF THE SUBCOMMITTEE

On July 1, 1941, a staff was set up for the Subcommittee on Nursing, under the executive secretary of the Health and Medical Committee. Alma C. Haupt (on loan from the Metropolitan Life Insurance Company) is nursing consultant to the Health and Medical Committee and serves as secretary to the Subcommittee on Nursing; James W. Staples is public information consultant. After an experimental period, the Health and Medical Committee requested that the position of executive secretary to the Subcommittee on Nursing be made a governmental responsibility for the "duration," and on January 1, 1942, the temporary position of "Principal Nursing Consultant" was established under Presidential Order, and classified by the Civil Service Commission. The salary of the public information consultant, plus a sum for the public information program of the Subcommittee, was pro-

vided by the American Red Cross for one year, beginning July 1, 1941.

On January 1, 1942, the position of assistant executive secretary of the Subcommittee on Nursing was created for one year, the salary being provided through a special gift to the American Red Cross for that purpose. Edith H. Smith, formerly professor of nursing and director of the nursing service at Stanford University Hospitals, came on the staff January 7, 1942.

#### RELATIONSHIPS WITH OCD

The Subcommittee on Nursing provided advisory service to the Medical Division of the Office of Civilian Defense, and the executive secretary of the Subcommittee on Nursing acted as nursing consultant to the Office of Civilian Defense until it became obvious that there was need for a nursing consultant on the staff of the Medical Division of the OCD. On October 1, 1941, Marian G. Randall was lent, on a part-time basis, from the Henry Street Visiting Nurse Service of New York City for this purpose, and engaged as a "special nursing consultant" under temporary Civil Service status.

In the establishment of the positions of "nursing consultant" under Civil Service in both the Subcommittee on Nursing and the Office of Civilian Defense, nursing is recognized by the government as having an integral part in war and defense activities, and opportunity is afforded to integrate nursing with the medical and social welfare programs of the federal defense agencies and to correlate it closely with the normal programs of the Federal Security Agency.

#### A PLAN FOR THE SUBCOMMITTEE

The functions of the subcommittee are:

1. To coordinate on a national level all nursing for defense in the government agencies and the American Red Cross.

# The Organization of Nursing in National Defense

On this page are depicted the organizations and agencies which are guiding nursing in the national defense program. The solid lines connecting the units in this diagram ——— indicate functional relationships. The broken lines ——— indicate cooperative relationships.

## Nursing Council ——— on National Defense

American Nurses' Association  
National League of Nursing Education  
National Organization for Public Health Nursing  
National Association of Colored Graduate Nurses  
Association of Collegiate Schools of Nursing  
American Red Cross Nursing Service

### EX OFFICIO MEMBERS

Federal Nursing Services  
Army Nurse Corps  
Navy Nurse Corps  
U. S. Public Health Service  
U. S. Veterans Administration  
Office of Indian Affairs  
Children's Bureau  
Canadian Nurses Association  
Subcommittee on Nursing  
Representative from staffs of national nursing groups and the American Journal of Nursing and Public Health Nursing

### EXECUTIVE COMMITTEE

Julia C. Stimson, R.N.  
Susan C. Francis, R.N.  
Sister M. Olivia, R.N.  
Stella Gootray, R.N.  
Marion W. Sheahan, R.N.  
Mary Beard, R.N.  
Mabel K. Staupers, R.N.

EXECUTIVE SECRETARY  
Elmira B. Wickenden, R.N.

## The President of the United States

## Office for Emergency Management

Office of Defense  
Health and Welfare Services  
Paul V. McNutt, Director

Office of Civilian Defense  
James M. Landis  
Director

Health and Medical Committee  
Irvin Abell, M.D., Chairman  
James A. Crabtree, M.D., Executive Sec'y.

Medical Division  
George Baehr, M.D.  
Chief Medical Officer

## Liaison to Subcommittee —

Amer. Red Cross Nursing Service  
Federal Nursing Services  
Army Nurse Corps  
Navy Nurse Corps  
U. S. Public Health Service  
Hospital Division  
States Relations  
U. S. Veterans Administration  
Office of Indian Affairs  
Children's Bureau  
Office of Civilian Defense

## Subcommittee on Nursing

Marion G. Howell, R.N., Chairman  
Julia C. Stimson, R.N.  
Marion W. Sheahan, R.N.  
Nellie X. Hawkins, R.N.  
Sister M. Olivia, R.N.

EXECUTIVE SECRETARY  
Alma C. Haupt, R.N.  
Edith H. Smith, Ass't.

PUBLIC INFORMATION CONSULTANT  
James W. Staples

## SPECIAL CONSULTANTS

1. NURSING EDUCATION  
Elizabeth Soule, R.N.  
Isabel M. Stewart, R.N.  
Anna D. Wolf, R.N.
2. RECRUITMENT OF STUDENT NURSES  
Katharine Faville, R.N.

-- Nursing Consultant  
Marian G. Randall, R.N.

2. To act as a two-way channel between the government agencies and the Nursing Council on National Defense.

3. To assist the Health and Medical Committee and its various subcommittees in all questions dealing with nursing.

4. To act as the Nursing Advisory Committee to the Office of Civilian Defense.

5. To suggest federal legislation regarding nursing and to assist in the development of a policy under which nursing programs are carried out.

6. To advise the U. S. Public Health Service on the nursing education program.

#### PROGRAM OF SUBCOMMITTEE

The Subcommittee on Nursing is advisory rather than administrative and acts as a so-called "parent committee,"

allocating to appropriate governmental and private agencies the jobs that need to be done.

The problem facing nursing in the emergency is twofold: (1) to provide adequate personnel (2) to organize the needed types of nursing service by implementing them with necessary administration, financial support, and standards of operation. The activities of nursing in meeting these problems are outlined as follows and include responsibilities being handled administratively by various federal and private agencies, the Subcommittee on Nursing acting chiefly in an advisory and coordinating capacity in relation to them.

#### PROBLEMS DEALING WITH PROVIDING ADEQUATE PERSONNEL

##### *The graduate nurse*

1. Three hundred thousand nurses have answered a national inventory supported jointly by the Nursing Council on National Defense, the Subcommittee on Nursing of the Health and Medical Committee, the American Red Cross, and the U. S. Public Health Service. The Public Health Service has charge of the administration of this project and has had valuable assistance from the Work Projects Administration. Suggestions have been given to state nurses' associations and their local branches as to the utilization of the data. On the basis of a sampling of 25 percent of the returns, it is estimated that there are 20,000 young, inactive nurses who may be able and willing to return to active civilian service. Marriage is the chief cause of turnover in the nursing profession.

It is estimated that there are 100,000 nurses who did not answer the original questionnaire.

2. The Subcommittee on Nursing receives quarterly reports from all federal nursing services of (1) the number of nurses on duty (2) the vacancies for which salary is provided (3) the addi-

tional number needed in the next three months.

The figures are then correlated with available figures of private agencies as secured through the Nursing Council on National Defense. As of January 1, 1942, after war was declared, the figures roughly showed the following needs:

Army and Navy.....	11,000
Institutions .....	10,000
Public health.....	10,000
Total .....	31,000

3. The United States Public Health Service, through its Division of Public Health Methods, has sent a questionnaire to public and private hospitals and health agencies including information regarding the number of nurses and auxiliary nursing personnel on hand, positions vacant, and anticipated number in the next three months. It is hoped that this may be kept up on a quarterly basis.

Since war was declared, the figures on the needs of the Army and Navy are confidential. However, the calling out of four base hospital units of 125 nurses each focuses anew attention on the prob-



lem of supplying the military forces and at the same time keeping civilian hospital and public health services intact.

4. Red Cross enrollment. Traditionally, the American Red Cross enrolls nurses for the First Reserve, from which the Army and Navy secure nurses. It requires normally a pool of five nurses under 40, unmarried, and physically fit, to get one into service. Hence, the First Reserve of 25,700 nurses as of January 1 must be increased to well over 50,000 to get the minimum of 10,000 nurses needed by the armed forces. It is, of course, anticipated that the needs of the Army and Navy will be greatly augmented.

The American Red Cross also has a Second Reserve of 43,408 nurses who are unavailable for military duty but are available for disaster, wartime epidemics, and to reinforce nursing staffs in civil hospitals and in public health work related to civil defense.

5. Procurement and assignment. The demand for nurses has led the Subcommittee on Nursing to consider some plan similar to that of the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, to adjust the needs of military and civilian services and to give recognition through insignia, buttons, or some other tangible device, to those who serve their country by remaining in necessary local civilian jobs. This is in the process of consideration.

6. Federal aid for nursing education. Inasmuch as the Army and Navy requirements are for graduate, registered nurses, the only way this need can be met is by increasing immediately the number of students in schools of nursing.

A program for federal aid for nursing education was initiated by the Nursing Council on National Defense through a study made by Isabel Stewart in collaboration with the U. S. Office of Education. This program was endorsed by the Health and Medical Committee and

the Subcommittee on Nursing. It was interpreted to the Congress by Mrs. Chester C. Bolton, Mary Beard, and Dr. James A. Crabtree.

An appropriation of \$1,250,000 was made by Congress on July 1, 1941 for the expansion of basic courses for undergraduates, refresher courses for those who have been inactive, and postgraduate courses in such specialties as supervision, public health, midwifery, and anesthesia. The program is administered by the U. S. Public Health Service.

The Subcommittee on Nursing has recommended that an appropriation of \$4,000,000 be sought for the fiscal year beginning July 1, 1942. Indications at the present time are that the budget bureau will recommend \$2,000,000 to the Congress.

#### *Recruitment of student nurses*

In view of the shortage of nurses and the fact that it takes three years to prepare a graduate nurse, the Subcommittee on Nursing estimates that instead of the usual 35,000 admissions a year to schools of nursing, 50,000 or an additional 15,000 will be needed. A Committee on the Recruitment of Student Nurses was formed by the Nursing Council on National Defense. The chairman of this committee was tied in with the Subcommittee on Nursing by being made Special Consultant on Recruitment to the Subcommittee. The indications are that the spring enrollments for 1942 will only bring the figures to 45,000, hence it was necessary to give quick emphasis to recruitment if the additional 5000 well prepared young women were to enter accredited schools this spring.

To this end, state nursing councils on defense have been formed in the states, the first job being to form a recruitment committee. A national, state, and local program of public information is now under way.

It is a question whether the accredited

schools of nursing are equipped in terms of teaching staff, clinical facilities, and physical accommodations to take more than 50,000 students. Also, there is the problem of competition with other current opportunities for women in defense, and of attracting 50,000 qualified candidates a year into professional nursing.

#### *Volunteer nurse's aides*

In order to assist the depleted graduate nurse staffs of civilian hospitals and health agencies, the American Red Cross and the Office of Civilian Defense have jointly sponsored a program to provide 100,000 volunteer nurse's aides.

### PROBLEMS DEALING WITH PROVISION FOR VARIOUS TYPES OF SERVICE

#### *Hospital nursing service*

The reduction of medical personnel in hospitals is throwing added burdens and responsibilities on nursing staffs, and the depletion of nursing staffs is requiring a new job analysis of those functions which may properly be shared with volunteer nurse's aides, auxiliary workers, and volunteers.

#### *Public health nursing*

In total war, the need for adequate public health nursing in each community is emphasized. In 1941, there were 700 counties in the country which had no public health nursing service of any sort, and 31 cities with a population of 10,000 or more had no such service.

To meet the defense situation, the emergency health and sanitation act has made it possible for the U. S. Public Health Service to appoint public health nurses. State health departments have requested 500 nurses but the federal funds have permitted employment of only 151. These nurses are employees of the U. S. Public Health Service assigned to state health departments, which in turn reassign them to local defense areas where they work under an official agency.

The lack of hospital facilities, particu-

These aides work under the supervision of the graduate nurse and their training and supervision on the job make new demands in keeping up the number of nurse teachers and supervisors in civilian hospitals.

#### *Nursing auxiliaries*

It is recognized that in addition to graduate nurses and volunteer nurse's aides, the emergency situation calls for additional personnel, whether on a pay or volunteer basis. To this end, a category of "nursing auxiliaries" has been set up, within which come WPA and NYA hospital workers.

larly in rural areas, also makes it important that public health nurses be available and that they give bedside nursing care as well as assist in communicable disease control and health education.

The Farm Security Administration, under the Department of Agriculture, has 50 nurses in resettlements and provides funds for 50 nurses serving migratory camps.

#### *Private duty*

Private duty nurses, 180,000 strong, constitute our biggest pool of resources. Many of these will volunteer for services in the armed forces. Others will replace nurses in hospitals. This puts upon the public the necessity to use private duty nursing only where it is most necessary and upon hospitals the need to develop group nursing, whereby one nurse may serve more than one patient.

#### *Nursing in disaster and in emergency medical services*

Through the Office of Civilian Defense, plans are made for the utilization of nurses and nurse's aides in field unit squads and also for the services of public health nurses in home visiting of the injured released from casualty stations and hospitals.

The American Red Cross also has a well organized plan of disaster nursing. As this is written, the Red Cross is arranging to send 75 Second Reserve nurses to the Territory of Hawaii for use in civilian hospitals. Second Reserve nurses served in San Francisco, receiving the wounded from Pearl Harbor and assisting them in getting to hospitals. In case of an "incident" it may be necessary to pool all local nursing resources under one central service and to have flexible interchange of nurses in hospital, private duty, and public health service.

#### *Nursing in first aid*

All nurses are being encouraged to take first-aid courses and as many as possible to prepare themselves to become instructors in first aid through the joint efforts of the American Red Cross and the Office of Civilian Defense.

#### *Home nursing*

The American Red Cross is expanding home-nursing classes, setting as a goal at least one-half million participants this year. This makes a demand for many additional nurse teachers and provides a suitable opportunity for married nurses who can only give part-time service to make a valuable contribution to national defense. For this expansion, 15,000 part-time nurse instructors are needed, of whom 5000 have already signed up.

#### OTHER COUNTRIES

##### *Canada*

Every effort is being made to keep in close touch with the war nursing developments in Canada through personal interviews, when possible, and through interchange of information.

##### *Great Britain*

A questionnaire was prepared regarding the British nursing situation, the answers to which have just been received from Gertrude Madley, chief nurse of the American Red Cross-Harvard Field Hospital Unit. This material will

be summarized and used as a basis for comparison.

#### *Latin America*

Through the Office of the Coördinator of Inter-American Affairs, the Subcommittee on Nursing has been asked to advise on the setting up of home-nursing and first-aid classes in Latin American countries and in the utilization of nurses in civilian defense projects.

A conference has been held by the Subcommittee of representatives of all nursing committees having an interest in Latin America.

#### PUBLIC INFORMATION PROGRAM

The public information program of the Subcommittee on Nursing is being correlated as closely as possible with that of the Nursing Council on National Defense. Of the \$6000 budget provided for the Subcommittee by the Red Cross, over \$2000 has been made available to the Nursing Council for recruitment.

The public information consultant acts as a coördinator of the various public information programs in governmental agencies that deal with nursing. He brings to the attention of these various services the nursing story and makes contacts for them with the radio, press, and other channels of information.

Also, the public information program of the Subcommittee comes under the whole public information program of the Office of Defense Health and Welfare Services which in turn is related to many governmental agencies, particularly the Office for Emergency Management. Hence many opportunities exist for making the nursing story known to the public.

National news releases, feature stories, spot announcements, radio interviews, and a radio script on nursing in defense are some of the methods already in use. Contacts have been made with national magazines. Material is constantly supplied to inter-office circulars and such

magazines as *Defense* and *Victory*. The handling of contacts with national radio, magazines, and newspapers (regarding recruitment of student nurses) is now being left to the Nursing Council. The Subcommittee on Nursing concentrates on contacts that can best be made in Washington.

#### CONCLUSION

In conclusion there are two major emphases to be made. First, the nursing profession is now so organized nationally for war and defense as to present a united front. This means that the Subcommittee on Nursing and the Nursing Council on National Defense are working in close and harmonious relationship with each other for nurses' part in victory.

The other is that for the past one-and-one-half years we have gone through three stages of: (1) setting up national machinery and doing countrywide planning (2) then developing state machinery—the state nursing councils—in which the state nurses' associations assumed leadership (3) local planning. We now are in the stage in which local organization and local planning are of utmost importance.

We need only look at one community in which the calling out of a base hospital takes 35 of the teaching and supervisory staff from one of the leading teaching hospitals in the country to appreciate that we must know our local nursing resources; we must be analytical in reviewing every nursing job to eval-

uate its importance; we must be ready to share certain nursing functions with volunteer nurse's aides and nursing auxiliaries and at the same time maintain standards of service; we must be flexible in arranging for the necessary quick interchange of nurses from hospitals, private duty, or public health services locally as may be needed; and then we must be ready to transfer groups of nurses from one community to another if emergency demands.

The test now is to discover how we can spread nursing where it is most needed, whether to the military or to the civilian groups. With our troops departing for many parts of the world and with nurses on the very front lines of battle, we shall be called upon to make many sacrifices and many adjustments in local nursing service in our home communities. And in addition, there is already a demand for American nurses in countries that are now preparing civilian defense, to say nothing of the demand which will come in the reconstruction days following the war.

Nursing is traditionally based on the fundamentals of discipline, skill, and the ability to respond instantly to the nation's call for service. It is because of this that nursing is recognized to be of vital importance in this crisis.

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Based on a report presented before the Joint Boards of the national nursing organizations, New York, N. Y., January 24, 1942. Published also in *The American Journal of Nursing*, March 1942.

#### INFORMATION ON HOUSING

NURSES who are studying housing will find valuable sources of information in "More About Housing," a List of Publications and Visual Aids Selected Chiefly for Teachers and Students, which is available upon request from the United States Housing Authority. The list includes pamphlets, books, study guides, magazines, and news bulletins. A list of films and slides which can be borrowed free of charge or rented for a small cost can also be obtained by writing the Information Division, United States Housing Authority, Washington, D.C.

## News from the S.O.P.H.N.'s

**P**ROBLEMS of public health nursing in wartime were discussed from many angles at the fourth Annual Meeting of the Council of Branches in New York City on January 22. Eighteen states of the twenty which have branches of the National Organization for Public Health Nursing were represented at the meeting.

Attending also were the N.O.P.H.N. president, Grace Ross, who welcomed the group in behalf of the National; the staff; Mrs. Roger Young of New Jersey, representing the chairman of the Board and Committee Members' Section; Mrs. Frederick S. Dellenbaugh, Jr., lay Board member from Massachusetts; and Mrs. Elmira Bears Wickenden, executive secretary of the Nursing Council on National Defense.

The Council voted to recommend to the N.O.P.H.N. Board the acceptance of the Wisconsin Branch, which had requested membership. Its president, Doris Kerwin, was the representative of her S.O.P.H.N. at the meeting.

Interesting and stimulating reports were made by the various branches on their activities. Progress which has been made during the past year in the integration of health in the basic curriculum was reported. It was interesting to note the different stages of development in the plans of various states. In a few states, beginnings are being made through classes given to students in their senior year by public health nurses. Increasingly, the value of these lectures in terms of the rest of the curriculum is questioned, and emphasis is shifting from the student nurse as the focus of the public health nurse's attention to the faculty of the school of nursing which is responsible for the instruction of all the nurses in health nursing.

There is less concern with public

health nursing affiliations, through which a comparatively small number of students learn about health nursing, and more with other plans by which the faculties, as well as all the students of all the schools of nursing in a community, shall profit.

Following are some of the plans which are being tried out with success:

1. Planned observations in public health nursing agencies for students in the first, second, and third years. These are followed by discussion either in a class or conference, in which a representative from the agency is present.

2. Planned observation and conferences in public health nursing agencies for members of the school of nursing faculty. In some agencies this plan runs concurrently with the previous plan, for the faculty and students from the same school.

3. Planned intervisitation by the school of nursing faculty and the public health nursing agency personnel for the purpose of observing the work of the staff nurse and student nurse and the teaching program.

4. University courses in public health and public health nursing given by public health personnel for school of nursing faculties and followed by conferences to help the faculty interpret and apply the knowledge.

5. The inclusion of nurses who meet admission requirements but who are not public health nurses in the same class in principles of public health nursing with full-time public health nursing students.

The acute shortage of nurses with desirable preparation and experience in orthopedic nursing was brought out. The need is being met somewhat by the awarding this year of nine scholarships in the public health field, administered by the N.O.P.H.N. and financed by the National Foundation for Infantile Paralysis. The institutes conducted by the N.O.P.H.N. consultant in orthopedic nursing in the Midwest and in the East were declared to be extremely helpful, and states receiving this service are eager to have the conferences repeated. Two



states reported very helpful institutes conducted by members of their own staffs.

A roll call showed five states with orthopedic committees in the S.O.P.H.N.: Arkansas, Massachusetts, New Jersey, Pennsylvania, and Washington. Massachusetts has a joint committee with representation from the State League of Nursing Education and the S.O.P.H.N.

Eleven states of the eighteen represented at the meeting reported industrial nursing committees or sections. Several states mentioned an increase in number of industrial nurses and the need for more industrial nurses to meet the needs of expanding defense industries. Various plans through which industrial nurses are securing help with their problems were discussed, including institutes, resident and extension courses on subjects of special interest to nurses in industry, and participation with other public health groups in meetings.

The contribution which industrial nurses can make to community planning and program planning and the importance of their participation from the beginning in any plans concerning their own field of activity were stressed. The increasing use of industrial nurses on important committees—particularly in relation to defense activities—was reported. The need for gearing programs and courses to meet the specific problems which these nurses face on the job was emphasized. The value of part-time nursing service as an entering wedge to demonstrate the value of industrial health service was brought out, and the stimulation of service to industry by public health nursing agencies was urged.

A wide range of lay activities was reported from various states. These included use of lay people on S.O.P.H.N. membership committees, on defense committees, and on committees to study needs for changes in organization due to defense; regional conferences for lay sections; institutes for lay people;

preparation of a manual for laymen and a history of public health nursing in the state; participation in defense activities, such as helping (1) to secure nurse representation on local defense councils (2) to initiate a state register of nurses for disaster (3) to secure recognition for volunteer service in existing health organizations as defense work.

The suggestion was made that industrialists or wives of industrialists should be considered for lay membership on committees to stimulate their understanding of health needs in industry and the use of community resources to meet these needs.

The value of giving lay people definite responsibilities was stressed, as a means of stimulating interest and securing the contribution which they have to make. It was agreed that lay membership and activity comprise one of the principal values of a state organization for public health nursing.

Continued growth in N.O.P.H.N. membership was shown in the report given by Ruth C. Marvin, N.O.P.H.N. business manager. The 1941 increase of 421 over 1940 is about the same as the previous year's increase. The increase in lay members this year, due to a special drive by Detroit nurses, is of special interest in showing what an intensive effort of nurses can do.

The states are functioning in various ways in state and local defense programs. Activities in which S.O.P.H.N.'s are assuming leadership or stimulating interest include the establishment of first-aid units or stations for emergency, the use of the nursing inventory to make up a register of nurses who have had public health experience, refresher courses for inactive public health nurses, and the teaching of home-nursing and first-aid classes.

State organizations are participating in various ways in the activities of the newly organized state nursing councils

*(Continued on page 167)*

# Nursing in a California Defense Area

By ANNAMAE I. MAHANEY, R.N.

**Public health nurses help this defense area to meet new health problems arising from population changes, and to prepare for wartime emergency**

**I**N THE past three years Monterey County, California, has suddenly become an important defense area. There are four large army fortifications and three army air bases in this area, and the navy will soon have a base near Monterey Bay. Until the defense program began, this county consisted largely of a rural population. In the rich Salinas Valley—called the salad bowl of the world—are vast lettuce, bean, and other vegetable fields; in the south are dairy farms and cattle ranges; and on the county's nearly 100 miles of western coast line are fishing industries and the art colony of Carmel. The county covers 3330 square miles and has an estimated population of 100,000 exclusive of enlisted men and officers. Sixteen public health nurses are employed in this area, only twelve of whom are under the supervision of the county health department.

Our new problems, then, are caused by the influx of defense workers and other people attracted to this community of individualists by the almost boom-town activities. For several years migrant workers from the dust-bowl area have been coming into our county with its stable population, bringing health and social problems of poverty, malnutrition, and overcrowding due to unemployment. Now the military and defense personnel have crowded into the community life, upsetting the long established habits of the citizens. Our public health nursing program is being set up

to encourage this combined new and old public to accept more responsibility for the health and welfare of themselves and of their community.

The health department in Monterey County is part of a consolidated health service. The medical director, who heads the defense medical and health activities, is also responsible for the management of the county hospital and sanatorium. His assistant, who is the health officer, directs the activities of the public health personnel. Thus, an agency has already been set up to coordinate the health and medical services.

In the organization of our local emergency medical services, public health nurses have not been assigned to first-aid stations. We believe that their program should remain essentially the same as during peacetime, except that their efforts in group teaching will be intensified and they will have specific duties in evacuation areas and shelters.

Soon after war was declared, one of the public health nurses conducted an intensive refresher course for other members of the staff to assist them in teaching home nursing classes with the coöperation of the American Red Cross. Certain phases of the regular course were particularly emphasized, such as how to improvise and use material found in the home in taking care of the sick, how to give simple nursing care, and how to maintain health by good hygienic habits.

Now practically all the nurses on the staff are conducting at least one home

nursing class each—as well as several registered nurses who have received assistance in planning their lessons from members of the health department staff. In addition to the practical material presented, emphasis is placed on the importance to every adult of keeping himself and his family in good health as a war-time necessity. The nurses point out that the nation needs the manpower of every individual, and that sickness is a drain on the nation's resources. They explain that our inadequate hospital facilities cannot accommodate all patients in an emergency. Therefore, many convalescents may be sent home to recuperate and some member of each family should know how to give simple nursing care. But the nurses do not forget to tell their students that this basic knowledge of nursing will be of lifetime value.

As good citizens they use their influence with the families—based on the confidence earned by working in the homes—to encourage them to accept more public responsibility. The nurses point out the importance of sacrificing individual rights for the rights of many and of cooperating with civilian defense regulations even if they are inconvenient; the need for self-discipline; and the value of each person's effort in making the defense program effective. They stress the importance of planning in advance for an emergency. They encourage parents to keep a supply of food on hand and to take some food in the automobile when they are traveling with small children.

In case of actual attack, each public health nurse is assigned to a district—in most cases her regular district—where she will give or assist with visiting nurse service, using volunteers from her home

nursing classes as aides. The public health nurse will serve in an advisory capacity to the aides.

In evacuation areas and shelters, the public health nurses will assist in the control of communicable diseases by directing the setting up of sound hygienic measures and isolation units. The care of mothers and children and the physically handicapped will also be an important part of their duties. Public health nurses, through their experience in working with people and in improvising, have long been accustomed to working under far from ideal surroundings, and so the shelters or evacuation areas will be just another place for them to put into practice their ingenuity.

Another important part of their duties will be to cooperate with other health and defense workers and to have knowledge of their programs. The nurses will need to be familiar with general instructions for protecting the water supply, the sanitation of the shelters, where decontamination stations are located in their districts, and how to direct people to proper facilities.

So far we have not succeeded in correlating as many of our efforts as we could. In the beginning much red tape had to be cut in order to get the program into effect. Now we are working toward a clarification of responsibilities, avenues for the transmission of information, and general guiding policies.

One of our greatest problems is the resistance encountered when we attempt to reduce the amount or change the kind of public health nursing service we are now giving in a community. So far, the nurses have taken on just another load, but after we have conducted a few more home nursing classes we hope to present our problems to a better informed public.

# The Skin Is the First Line of Defense

By BEULAH FRANCE, R.N.

NEVER WAS there a greater need for illness prevention in our nation than now. People must be taught how to stay well. The call to the colors of doctors and nurses, the rapid rise in prices of drugs, the scarcity of supplies, the cost to the family of sickness and its interference with production—all these point to the need for a drastic cut in preventable illness and in the time taken for recovery from illness.

If every public health nurse would accept as her duty the task of making the civilian population aware of the dangers that lurk in the tiniest cut, scratch, or pinprick, unless promptly and properly treated, inestimable saving in every sense of the word could be achieved.

The increased interest in first-aid classes everywhere has called attention to the proper care of all kinds of wounds. The uses and precautions in the use of iodine—a skin antiseptic which has stood the test of time for many purposes—are well described in the American Red Cross *First Aid Text-book* which is the guide for thousands of first aiders throughout the country.

"Apply iodine immediately to the smallest skin break, for only a whole skin is safe." This might well be the slogan adopted. And with it should go full directions for the antiseptic's use, with an explanation about the new, mild tincture of iodine, popularly called "iodine antiseptic solution," which neither stings nor burns and is officially recognized by the United States Pharmacopoeia.

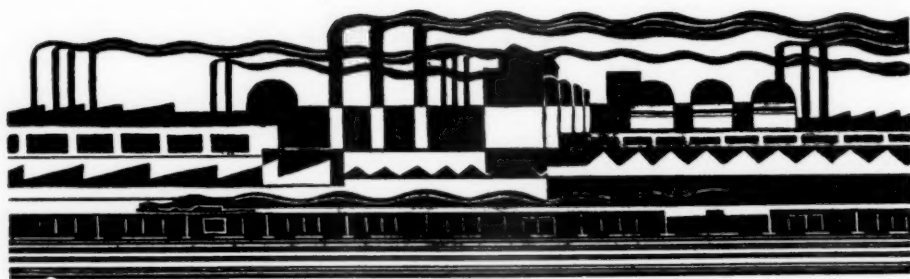
Iodine stood the severest possible tests under the most trying circumstances in the first World War. It not only held its place, undefeated and ready

for World War Two, but showed it could serve even better and less expensively in milder forms than did its originally used stronger tincture.

Every school nurse of course has an iodine supply on hand. But does she always take time to teach the students how to use it at home? Does she instruct them to keep it in a bottle with a glass or rubber stopper and to see that the bottle is closed tightly in order to prevent evaporation of alcohol so that the iodine does not become too strong? Does she tell them to keep the bottle labeled and out of the reach of small children? They will be interested in learning how to apply it with the glass rod applicator or with a clean cotton applicator made with a toothpick or matchstick. Especially they should be told to apply it "well down into the wound" and "then on the skin around the wound."<sup>1</sup> They should be cautioned to let it dry before applying dressings; not to use it near the eyes; and not to reapply it to the same place.

These points are important, as is the necessity for prompt medical attention when an injury is at all serious. A puncture wound, for instance, demands medical attention at the earliest possible moment in addition to "working iodine well down into the wound." No one needs to be told of the necessity for medical care of a patient with a compound fracture, but first aiders learn how to "treat the wound as any other wound with mild tincture of iodine, sterile dressing, and bandage. If the bone is protruding through the wound, apply the iodine over the end of the bone and well around the wound."<sup>2</sup>

(Continued on page 175)



## STUDY OF INDUSTRIAL NURSING DUTIES

A MEETING of the Committee to Study the Duties of Nurses in Industry, of the Public Health Nursing Section, American Public Health Association, was held in New York City on November 23, 1941, to discuss further plans for the study which is being made in co-operation with the Division of Industrial Hygiene of the U. S. Public Health Service. A preliminary report of this study was made at the annual meeting of the A.P.H.A. in Atlantic City, New Jersey, October 15, by Olive M. Whitlock, chairman of the committee. Representatives from industrial nurses' groups in Western Massachusetts, New York City, New Jersey, Connecticut, Indiana, and Delaware participated.

Suggestions were made for revising the form used in the preliminary survey, and the procedure to be used in

collecting the data was determined. The Committee decided to enlarge its membership by inviting representatives from the American Nurses' Association and the National League of Nursing Education to participate, and to establish a consultant board composed of representatives from the American Association of Industrial Physicians and Surgeons, the American Industrial Hygiene Association, the American Medical Association's Council on Industrial Health, the National Conference of Governmental Industrial Hygienists, and the National Association of Manufacturers' Committee on Healthful Working Conditions.

The study, which will be the first comprehensive survey of duties of nurses in industry, will require approximately one year.

## WORKERS' HEALTH AND THE 24-HOUR SCHEDULE

SURGEON GENERAL Thomas Parran, of the United States Public Health Service, recently issued the following statement with especial regard to the number of industrial establishments operating on a 24-hour-a-day schedule:

As in the first World War, American industry is faced with the problem of 24-hour-day, 7-day-week operation. Fatigue is a health hazard and a hazard to continuous produc-

tion. The addition of second and third shifts to plant schedules necessitates the establishment of the rotating shift.

To maintain workers' health and thereby peak production, industries operating on the 24-hour basis must take special precautionary measures to minimize the effects of night work and the rotating shift. The United States Public Health Service makes these recommendations:

1. Workers changing over from day to night



shift every two or three weeks find it difficult to adjust their eating and sleeping habits. In plants operating on a 24-hour schedule, shifts should not be rotated more often than every two or three months.

2. Each nursing shift should rotate at the same time as the workers' shift, so that the same nurses will always be acquainted with the workers they are treating.

3. Women with home responsibilities often try to do their housework during the day while working on night shifts. Chronic fatigue in short order is the result. In general, women workers who also have domestic duties should not be employed on the night shift.

4. A 60-hour week—on a 10-hour day, 6-day week basis—may become necessary. Excessive increases in working hours lead to reduced efficiency during working hours, absenteeism, and sickness. A 48-hour week—on an 8-hour day, 6-day week basis—is preferable. Individual workers should have one day in every 7 days reserved for rest and recreation; this does not preclude continuous operation of the factory.

5. Organized rest periods help maintain production at a high level. Five- to fifteen-minute rest periods should be provided at the end of the first quarter, and again at the three-quarter mark of each shift. This is especially

important in repetitive, monotonous work or heavy manual labor. Milk, soft drinks, sandwiches, and candy should be available during the rest periods.

6. A particularly high standard of lighting is necessary in plants operating at night or under blackout conditions. Proper lighting reduces fatigue, improves morale, and prevents accidents due to poor light or glare.

This six-point program should be based on the broader industrial hygiene service advocated by the United States Public Health Service which includes:

Medical and nursing services available to workers on each shift; good plant housekeeping; adequate sanitary facilities; adequate ventilation; control of exposures to hazardous operations or to noxious dust, fumes, and gases; proper placement of workers in jobs for which they are physically and temperamentally suited; reduction of excessive noise (a well known fatigue producer); health and safety education programs, such as teaching proper posture on the job, sanitation, nutrition, and mental hygiene; paid vacations of at least one or two weeks a year.

—From *Industrial Hygiene*, issued by the Division of Industrial Hygiene, U. S. Public Health Service, January 1942.

## INDUSTRIAL HYGIENE COURSES

A PROGRAM of study in industrial hygiene is being offered this semester by St. Louis University, St. Louis, Missouri, for supervisors or consultants in this special field. Admitted to the course were nurses who had completed a program of study in public health nursing and selected students with extensive industrial and administrative experience if such experience met with the approval of the Committee on Admissions. The program consists of the following courses: Industrial Hygiene for Nurses, Field Experience in Industrial Hygiene, and Seminar in Industrial Hygiene for Supervisors. Nurses who are employed may be admitted for one course, Industrial Hygiene for Nurses.

A two-point extension course on indus-

trial hygiene has been offered during the winter semester by Teachers College, Columbia University, under the auspices of the Visiting Nurse Association of the Oranges and the Newark Visiting Nurse Association. The course was "designed to give a practical understanding of the health hazards of industry, and a general knowledge of the most common industrial diseases." The class met once a week for two hours in the evening, in Newark, New Jersey.

A course on Industrial Hygiene for Nurses was started in January 1942 in Oakland, California, by the Extension Division of the University of California, under the direction of Dr. Robert T. Legge, professor of hygiene in the University of California at Berkeley.

# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

## BOARD CONSIDERS WARTIME NEEDS

PUBLIC HEALTH NURSING service in wartime was the theme that underlay each report given and every action taken at the annual meeting of the N.O.P.H.N. Board of Directors held January 24, 1942, at the Roosevelt Hotel in New York City.

Opening remarks of the president emphasized the fact that the Organization is carrying out the wishes of the Board in its policy of considering defense activities as first business now that we are at war.

Some of the activities undertaken recently in response to requests by federal agencies were mentioned by the general director, as for example, the compilation of a list, by states, of all the voluntary public health nursing agencies in the country to be used in a study of public health personnel; and an estimate of the number of automobiles used by public health nurses, to be used in relation to the rationing of tires.

Three problems on which individual and agency members are asking advice were brought by the general director to the Board for consideration. The first question has to do with the preparation and use of volunteer aides, who are needed increasingly by public health nursing agencies to supplement the work of nurses in this crisis. A special committee was appointed to outline suggestions on the use of these aides.

The second question concerns the extent to which it is possible to release public health nurses for military service and other services needed because of the war and still maintain essential local public health nursing services. Discussion of coöperative action of the Subcommittee on Nursing of the Health and

Medical Committee with the national nursing organizations to help solve this problem appears at the end of this report.

A third question relates to desirable content of refresher courses for inactive nurses who are willing to help their local communities in this time of crisis. A special committee was appointed to develop a plan for these courses.

The budget presented by the Finance Committee was also based on war needs. In order to help finance the Nursing Council on National Defense and to meet rising costs of operation, the Board approved expenditures totaling \$140,048 for 1942, while the anticipated current income is only \$121,000. The reserve fund of the organization, built up over a period of years for a possible emergency, will be used to meet the deficit. It was the opinion of the Board that the emergency is now upon us, and that this reserve fund should be made available for needed services.

The splendid report from the Membership Committee encouraged the Board to hope that further increases in membership dues will mean some additional income in 1942. Amelia Grant, chairman, stated that the efforts of state membership representatives had resulted in a total of 11,182 members in 1941, an increase of 421 over 1940. It seems probable that more public health nurses than ever before will, in the present emergency, feel the importance of the coöordinated effort which is made possible through their National Organization.

Reports of the School Nursing and Industrial Nursing Sections both showed awareness of war problems. In relation to industrial nursing especially, it was recognized that the war has brought a

need for expansion of health service to employees, in which public health nurses must take part.

Mrs. S. Emlen Stokes, chairman of the Board and Committee Members' Section, told of the volunteer work done by the Section's Executive Committee since its secretary was lent for six months to the U. S. Office of Civilian Defense. In response to the OCD's request for an extension of leave of absence for the secretary, Evelyn K. Davis, the Board granted an extension for an additional six months with the understanding that by July her early return would be arranged or some other plan made for continuing this work.

The Council of Branches reported that it had devoted its afternoon session to a discussion of defense activities with Mrs. Elmira Bears Wickenden, executive secretary of the Nursing Council on National Defense, who attended the meeting. The Council recommended that each state branch be urged to cooperate with state nursing councils on defense and to help in every possible way with the defense programs of their states. The Council also announced with pleasure the formation of an S.O.P.H.N. in Wisconsin and this new organization was accepted by the Board as a branch of the N.O.P.H.N.

The Committee on Nursing Administration sought approval of the Board for several undertakings which will help local communities to work out plans for carrying on essential services with a minimum number of workers. Among other things the Committee plans a brief study of nursing service in clinics to find out what are the duties ordinarily performed by nurses in clinics; to analyze data in order to consider the relative importance of these duties; and to evaluate insofar as possible public health nursing service in clinics as compared with other types of public health nursing service.

Since every activity which promotes

good nursing education may well be considered as defense work, the recommendations of the Education Committee which were approved by the Board hold special interest. Included are recommendations for: (1) the appointment of a joint committee of the National League of Nursing Education and the N.O.P.H.N. to study the whole question of integration of the health and social aspects of nursing in the undergraduate curriculum (2) a study to be made of the desirable ratio of students to staff and supervisors to staff and students in order to utilize the field for student practice effectively (3) a recruitment campaign on a selective basis for the field of public health nursing to be undertaken by the N.O.P.H.N.

The most important part of the Education Committee report was the recommendation that the Curriculum Guide in Public Health Nursing—whose preparation was a joint project of the N.O.P.H.N. and the U. S. Public Health Service—be accepted and approved with grateful appreciation for the work done by all those participating in its preparation. It is expected that the Curriculum Guide will be published and available by the time of the Biennial Convention in May 1942.

The Publications Committee reported plans for giving priority in PUBLIC HEALTH NURSING magazine to defense news. The editorial policy to keep a balance of material will be continued, but because of limitation of space due to inclusion of defense items, greater attention will be given to careful selection of material in relation to quality.

Especially important is the need for a better quality of orthopedic nursing in this country for service both to the military and civilian population. The Joint Orthopedic Nursing Advisory Service of the N.O.P.H.N. and the National League of Nursing Education reported scholarships awarded to prepare teachers and supervisors for hospitals

and the public health nursing field, and institutes held in various parts of the country—both efforts directed toward improvement of orthopedic care of patients. The orthopedic service assisted during the epidemics of poliomyelitis which occurred during the past year in Georgia, Mississippi, and Alabama.

As a part of the nation's plans to promote good relationships among all American republics, the N.O.P.H.N. approved the appointment of a joint committee of the three national nursing organizations to sponsor visits of nurses from the Latin-American countries to the United States. This committee will communicate with the Office of the Coördinator of Inter-American Affairs to offer coöperation in promoting professional nursing in the Latin-American countries.

The last part of the Board meeting was devoted to the discussion of nursing problems created by the war as seen by nurses assigned to governmental agencies in Washington. Alma C. Haupt, executive secretary of the Subcommittee on Nursing in the Office of Defense Health and Welfare Services, Marion G. Randall, nursing consultant in the Medical Division of the Office of Civilian Defense, and Elmira Bears Wickenden, executive secretary of the Nursing Council on National Defense, led this discussion. Miss Haupt explained the plan for Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, set up under the Office of Defense Health and Welfare Services. She believes a similar plan must be developed for nurses, and the coöperation of the national nursing organizations will be asked in setting up principles to guide local nursing councils on defense in helping individual nurses decide whether they should remain in their present jobs or enter military or other war service.

Miss Randall pointed out relation-

(Continued to page 175)

## N.O.P.H.N. INCOME AND EXPENSE

1941

### Income

Membership dues, individual.....	\$ 33,294.00
Membership dues, agency.....	27,760.43
Contributions .....	17,957.90
*PUBLIC HEALTH NURSING magazine .....	25,614.81
Reimbursements .....	4,399.27
National Foundation for Infantile Paralysis .....	22,993.10
Miscellaneous .....	6,278.45
<b>Total income .....</b>	<b>\$138,297.96</b>

### Expense

Correspondence and Consultation.....	\$ 29,680.64
Field Service.....	24,150.03
Educational Service.....	10,986.44
Statistical Service and Studies.....	11,332.54
*PUBLIC HEALTH NURSING magazine .....	
a. Advertising .....	3,098.77
b. Preparation .....	7,257.30
c. Printing .....	8,311.06
d. Subscriptions .....	8,304.66
Publications and Bulletins.....	8,935.70
Nursing Council on National Defense .....	3,023.86
National Foundation for Infantile Paralysis .....	22,993.10
<b>Total expense .....</b>	<b>\$138,074.10</b>

### Summary

Income .....	\$138,297.96
Expense .....	138,074.10
<b>Income over expense .....</b>	<b>\$ 223.86</b>

### \*PUBLIC HEALTH NURSING Magazine

#### Income

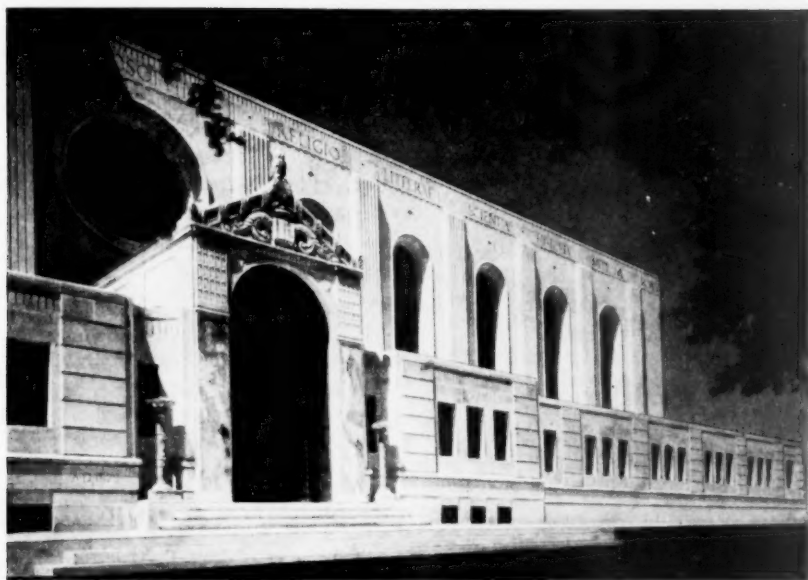
Subscriptions .....	\$20,181.01
Advertising .....	5,433.80
<b>Total income.....</b>	<b>\$25,614.81</b>

#### Expense (allocated)

General administration .....	\$13,967.56
Travel .....	244.80
Printing and miscellaneous expense .....	11,354.87
Subscription promotion.....	1,404.56
<b>Total expense.....</b>	<b>\$26,971.79</b>

#### Summary for magazine

Expense .....	\$26,971.79
Income .....	25,614.81
<b>Deficit .....</b>	<b>\$ 1,356.98</b>



Elizabeth M. Cudahy Memorial Library, Loyola University, Lake Shore Campus, Chicago, Illinois

### REGISTER EARLY FOR GROUP CONFERENCES

Registrations for the group conferences to be held preceding the Biennial Convention in Chicago, Illinois, on May 16 and 17, will be accepted in the order of application, and notification of acceptance will be sent as promptly as possible. No fee will be charged for the group conference on orthopedic nursing, which is made possible as a part of the special project in orthopedic nursing financed by the National Foundation for Infantile Paralysis, nor for the conference on industrial nursing. All of the other conferences are \$2 to members, \$4 to non-members, except the conference on business administration which is open only to agency members and is \$2. Registrations should reach the N.O.P.H.N. office, 1790 Broadway, New York, N.Y., before May 1.

The group conference on orthopedic nursing is planned by the Joint Orthopedic Nursing Advisory Service of the N.O.P.H.N. and the National League

of Nursing Education. Registration is limited to 60, of whom 30 are to be public health nurses actively engaged in orthopedic services in local agencies and nurses responsible for general staff education, and 30 will be head nurses, supervisors, and instructors in orthopedic services in hospitals.

The first day's session will be a joint one attended by both groups. On the second day, the group will divide into two round tables. The following program has been arranged:

May 16. Joint session, Rothschild Auditorium, Nurses' Residence, Michael Reese Hospital.

#### *Morning session*

1. Present status of the research into the causes, epidemiology, and prevention of poliomyelitis

2. The Kenny method of caring for the patient with acute poliomyelitis, with demonstration of body pack

#### *Afternoon session*

3. Body mechanics in nursing

4. Nursing responsibilities in skeletal injuries due to total war



and the public health nursing field, and institutes held in various parts of the country—both efforts directed toward improvement of orthopedic care of patients. The orthopedic service assisted during the epidemics of poliomyelitis which occurred during the past year in Georgia, Mississippi, and Alabama.

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a. Advertising .....	3,098.77
b. Preparation .....	7,257.30
c. Printing .....	8,311.06
d. Subscriptions .....	8,304.66
Publications and Bulletins.....	8,935.70
Nursing Council on National Defense .....	3,023.86
National Foundation for Infantile Paralysis .....	22,993.10
<b>Total expense</b> .....	<b>\$138,074.10</b>

### Summary

Income .....	\$138,297.96
Expense .....	138,074.10
<b>Income over expense</b> .....	<b>\$ 223.86</b>

### \*PUBLIC HEALTH NURSING Magazine

#### Income

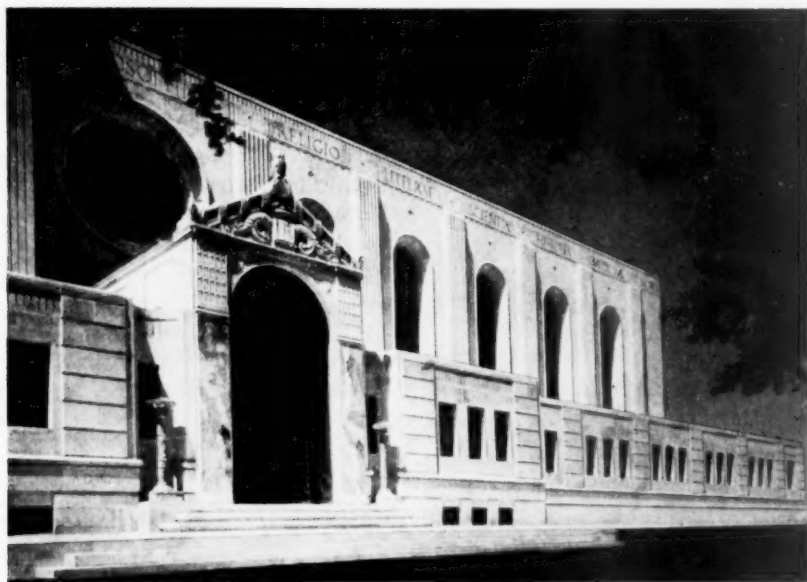
Subscriptions .....	\$20,181.01
Advertising .....	5,433.80
<b>Total income</b> .....	<b>\$25,614.81</b>

#### Expense (allocated)

General administration .....	\$13,967.56
Travel .....	244.80
Printing and miscellaneous expense .....	11,354.87
Subscription promotion....	1,404.56
<b>Total expense</b> .....	<b>\$26,971.79</b>

#### Summary for magazine

Expense .....	\$26,971.79
Income .....	25,614.81
<b>Deficit</b> .....	<b>\$ 1,356.98</b>



Elizabeth M. Cudahy Memorial Library, Loyola University, Lake Shore Campus, Chicago, Illinois

## REGISTER EARLY FOR GROUP CONFERENCES

Registrations for the group conferences to be held preceding the Biennial Convention in Chicago, Illinois, on May 16 and 17, will be accepted in the order of application, and notification of acceptance will be sent as promptly as possible. No fee will be charged for the group conference on orthopedic nursing, which is made possible as a part of the special project in orthopedic nursing financed by the National Foundation for Infantile Paralysis, nor for the conference on industrial nursing. All of the other conferences are \$2 to members, \$4 to non-members, except the conference on business administration which is open only to agency members and is \$2. Registrations should reach the N.O.P.H.N. office, 1790 Broadway, New York, N.Y., before May 1.

The group conference on orthopedic nursing is planned by the Joint Orthopedic Nursing Advisory Service of the N.O.P.H.N. and the National League

of Nursing Education. Registration is limited to 60, of whom 30 are to be public health nurses actively engaged in orthopedic services in local agencies and nurses responsible for general staff education, and 30 will be head nurses, supervisors, and instructors in orthopedic services in hospitals.

The first day's session will be a joint one attended by both groups. On the second day, the group will divide into two round tables. The following program has been arranged:

May 16. Joint session, Rothschild Auditorium, Nurses' Residence, Michael Reese Hospital.

### *Morning session*

1. Present status of the research into the causes, epidemiology, and prevention of poliomyelitis

2. The Kenny method of caring for the patient with acute poliomyelitis, with demonstration of body pack

### *Afternoon session*

3. Body mechanics in nursing

4. Nursing responsibilities in skeletal injuries due to total war

May 17. Round table discussions, Palmer House

Public health nursing group

Staff education and correlation of specialized and generalized services

Institutional group

Methods of clinical teaching as applied to orthopedic nursing

Final details regarding the other conferences including the names of all of the group conference leaders will be published in the April issue.

#### RECORDS ROOM AT BIENNIAL

A records reading room in which closed records will be available for study is planned for the Biennial Convention in Chicago, Illinois, May 17-22. The Records Committee of the National Organization for Public Health Nursing at its meeting on January 26, 1942, started work on securing copies of closed records from many parts of the country and from many types of agencies. Letters have been mailed to 70 agencies describing the plan and asking for copies of closed records. Mead and Wheeler, the company which publishes N.O.P.H.N. record forms and instructions, has offered the use of files and other equipment.

The Records Committee will be interested in receiving word of any particularly effective record forms or methods of writing records.

The types of service to be included in the records room material are as follows:

1. Acute communicable disease
2. Adult health supervision
3. Antepartum care
4. Day sheets and monthly reports
5. Delivery
6. Industrial health
7. Infant and preschool health supervision
8. Noncommunicable disease—bedside care and other
9. Nutrition
10. Occupational therapy record for the nurse
11. Orthopedic
12. Postpartum care
13. School health
14. Time-study schedules
15. Tuberculosis
16. Venereal disease

#### ORTHOPEDIC SCHOLARSHIPS

Nine scholarship awards to public health nurses made available through the National Organization for Public Health Nursing by a grant from the National Foundation for Infantile Paralysis are announced by the Joint Committee on Orthopedic Scholarships. The recipients of the scholarships are:

##### *To qualify for teaching position*

Lois Olmsted, The Visiting Nurse Association of Chicago, Chicago, Ill.

##### *For preparation for supervisory position with agencies having specialized programs*

Margaret Sprague Arey, formerly orthopedic nursing consultant, Division for Crippled Children, South Carolina Board of Health, Columbia, S.C.

Matie Magdalen Becker, formerly acting orthopedic supervisor, Visiting Nurse Association of Brooklyn, Brooklyn, N.Y.

Helen Sheridan Hartigan, orthopedic field nurse, Georgia Crippled Children's Service, Marietta, Ga.

Hildegard Johnson, orthopedic nurse, Visiting Nurse Association of Pawtucket and Central Falls, Pawtucket, R.I.

Margaret Phyllis Ladd, orthopedic consultant, Division for Crippled Children, South Carolina Board of Health, Columbia, S.C.

Millicent Elizabeth Nichols, The Visiting Nurse Association of Scranton and Lackawanna County, Scranton, Pa.

Jane Mary Thompson, Sigma Gamma Hospital School, Mt. Clemens, Mich.

##### *For preparation for supervisory position with agency having a generalized program*

Marian Hart Pratt, assistant supervisor of nurses, Henry Street Visiting Nurse Service, New York, N.Y.

#### TRIBUTE TO BOARD MEMBER

An editorial in *The Toledo Blade* (Ohio) for February 3, 1942 pays tribute to Grace S. Frost upon her retirement from the office of president of the Toledo District Nurse Association after 27 years of service. The editorial says: "Toledo will always be indebted to Miss Frost for her distinguished service in an undertaking which has helped countless thousands." Miss Frost is a member of the N.O.P.H.N. Board of Directors.

## CHICAGO HOTELS FOR BIENNIAL CONVENTION

HOTEL	ACCOMMODATIONS	RATES
Blackstone	Single with bath	\$4 and up
	Double with bath	7 and up
Congress	Single with bath	3 to 6
	Double with bath	5 and up
Palmer House (Headquarters N.O.P.H.N.)	Single with bath	3.50 to 7
	Double (double beds) with bath	5 to 9
	Double (twin beds) with bath	6 to 11
Stevens (Headquarters A.N.A. and N.L.N.E.)	Single with bath	3 to 6
	Double (double beds) with bath	4.50 to 8
	Double (twin beds) with bath	6 to 10

NOTE: For other information on housing accommodations write to Amelia L. Thie, chairman of the Subcommittee on Housing and Visitors, Illinois State Nurses' Association, Room 1014, 8 South Michigan Avenue, Chicago, Ill.

### News from S.O.P.H.N.'s

(Continued from page 156)

on defense and are working in close coöperation with other defense organizations.

Mrs. Elmira Bears Wickenden explained that state nursing councils on defense must include all nursing groups. If official groups such as state health departments and state boards of nurse examiners belong, the Federal Government will be able to transmit its instructions on defense programs to an authorized group. Instructions from the U. S. Office of Civilian Defense will be sent to regional and state defense councils to be transmitted to state nursing councils. The purposes of the state nursing council on defense are to coöperate closely with planning for:

1. Emergency programs for civilian protection, such as local nursing assistance in emergency medical units, Red Cross activities, and dissemination of information in coöperation with state defense councils.

2. Emergency and long-range programs which are professional in character, in which nursing leadership is necessary, such as the recruitment of student and graduate nurses and expansion of educational facilities.

She urged that S.O.P.H.N.'s respond *immediately* to instructions received from national agencies since time is of the essence.

The Council agreed that public health nurses can function more effectively in the defense program where they are organized in S.O.P.H.N.'s, and it voted to recommend to the N.O.P.H.N. Board of Directors that because of defense needs the National encourage the formation of S.O.P.H.N. branches in more of the states.

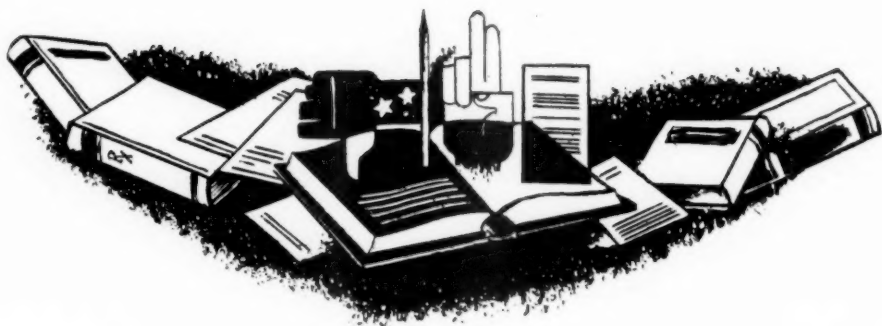
The Council voted to recommend to its Organizations that they stimulate interest and coöperate in every way possible with the state nursing councils on defense in their states, and that they help with the formation of a council in states where one is not already organized.

The Council also voted that recommendation be made to the N.O.P.H.N. Board that the National take some responsibility for setting up the content of refresher courses in public health nursing for the wartime emergency.

The officers elected for 1942 were Mathilda Scheuer of Pennsylvania, chairman; Adah L. Hershey of Iowa, vice-chairman; Evelyn T. Walker of New Jersey, treasurer; and Ella L. Pensinger, secretary.

Following the meeting, a tea was held at the headquarters of the Henry Street Visiting Nurse Service, with its executive staff and board members acting as hostesses.

P.P.



EDITED BY ANNA C. GRING

#### VISUAL PROBLEMS OF SCHOOL CHILDREN

By Emmett A. Betts, Ph.D., and Agnes Sutton Austin, M.S. 80 pp. Reprinted from *The Optometric Weekly*. The Professional Press, Inc., Chicago, 1941. \$1.

This publication is a report of a study of the vision of 126 fifth-grade pupils in the public schools of Huntingdon, Pennsylvania, with complete data on 109 cases.

An ophthalmological examination (with cycloplegia) was used as well as tests of reading and of mental maturity. Visual tests included Betts Visual Sensation and Perception Tests, Snellen for distance vision, and A.M.A. Reading Card for near vision, and others. The children were asked to check a "symptoms inventory" consisting of specific questions about subjective symptoms and tics.

Two purposes are stated for the study: (1) to apply what the authors call a new concept of vision—a "psycho-physiological" approach as contrasted to what they call a mechanistic approach, (2) to study the relationship of vision to reading achievement.

In a cumulative summary of six items, the authors indicate the need for referral for 66.37 percent of the children. The source of the figures in this summary is not clear since no cross tabulation is presented to enable the reader to learn in how many cases more than one of the six items are present. Visual acuity—

but not refractive errors—is included in the six items.

The report is a highly technical one requiring much study for proper evaluation both of the ophthalmological and the statistical material. The conclusions are interesting, but one finds supportive data difficult if not impossible to locate.

ELEANOR W. MUMFORD, R.N.

*New York, New York*

#### SO BUILD WE

By Mary S. Gardner, R.N. 223 pp. The Macmillan Company, New York, 1942. \$2.25.

Would you like to meet a friendly, warmhearted director of a visiting nurse association in an average American city who has found an answer to many of the posers in the daily administration of an organization? Then you will want to know Mary Melton who shares her joys and sorrows with you through the pages of Miss Gardner's new book, *So Build We*.

Miss Melton is very human and her problems are described in such a gay mood that the reader almost forgets—in the enjoyment of Miss Gardner's humorous touch—the agony of mind which can accompany such situations as unbalanced budgets. This book teems with the rich experiences gleaned from years of knowing and loving public health nursing. It might be described as a series of essays on human nature which will be appreciated by everyone



old enough to recognize their truth and beauty. *So Build We* will never have to be placed on a required reading list. It wins its own unique award as desirable reading.

DOROTHY DEMING, R.N.  
*New York, N. Y.*

#### SAFETY IN THE WORLD OF TODAY

By Herbert J. Stack, Don Cash Seaton, and Florence Slown Hyde. 372 pp. Beckley-Cardy Company, Chicago, 1941. \$1.20.

The wonderful progress of science as well as the hazards in modern living are carefully considered in this textbook on safety education. As children grow in their ability to control their environment and actions, their interests lead them to question procedures, to discuss problems, and to seek available information. This material on the use of science to prevent accidents, safety at home, in school, and in the community, and the importance of an understanding of the mechanism and use of the car should help children to recognize the imperative need for safe living today.

MARY B. RAPPAPORT, R.N.  
*Albany, New York*

#### METHODS OF ASSESSING THE PHYSICAL FITNESS OF CHILDREN

By Rachel M. Jenss, Sc.D., and Susan P. Souther, M.D. 121 pp. Bureau Publication No. 263, United States Department of Labor, Children's Bureau, Superintendent of Documents, Washington, D. C., 1940. 15c.

This monograph is the report of a study of New Haven children who were measured by the Baldwin-Wood height-weight table method, the ACH Index, the Nutritional Status Indices, and the Pryor width-weight tables. These methods of measurement are referred to as "... the more generally accepted methods of assessment of physical fitness ..." and the conclusion is reached that "... none of the four indices of body build ... proves an efficient method of identifying children included in this study who, according to the criteria, are likely to be physically unfit."

At the present time there is a rather general acceptance of the limitations of the Baldwin-Wood Tables as a device for selecting children in need of medical attention. This reviewer has not had experience with the Pryor method so he is not prepared to consider that part of the study. While it has been several years since the Nutritional Status Indices have been published, they have not had any widespread use. They are based upon the assumption that the size of the muscles, the amount of subcutaneous tissue, and the weight are significant indices of nutritional status when allowance is made for skeletal differences. This assumption is based on medical experience and judgment, but there is need for more experimental evidence to show the relationship of these indices to the desirable or undesirable conditions which may affect an individual child.

This study fails to meet this need. The authors use clinical judgment as a criterion of the child's general nutritional status, and they present evidence and many references to indicate how unobjective and unsatisfactory this criterion is. The other criteria concerned with average percentage weight gain and percentage change in arm girth are objective, but determination of the real meaning of these criteria presents a further problem of interpretation in regard to the comparison of children selected by this study.

The very small number of children selected by the Nutritional Status Indices suggests that either the group was atypical or the test should have been set to pick a larger proportion of children. Obviously the comparison has little value when so few or no children are selected for the comparison.

To assess physical fitness by any simple measurements is quite a different matter from discovering physical signs or symptoms that may direct attention to a child who may be in need of medical care. While the anthropo-

metric approach to this problem is still obscure, the medical evaluation of nutritional status by a group which is now cooperating with the Milbank Memorial Fund seems to offer a prospect for developing methods that will give us new light on this complex subject.

HAROLD H. MITCHELL, M.D.  
*New York, New York*

#### THE ROLE OF THE TEACHER IN HEALTH EDUCATION

By Ruth M. Strang, Ph.D., and Dean F. Smiley, M.D. 359 pp. The Macmillan Company, New York, 1941. \$2.

This book should be of great value to

those who are trying to integrate health teaching with the entire school program. The authors give concrete examples of methods of coordinating health education with the rest of the curriculum, taken from experiences reported by educators in various schools throughout the country. The presentation of health problems and needs of students is comprehensive, and should give the teacher a basis on which to begin her health program. The book should be useful to school nurses and other public health nurses.

LUCY PERRY, R.N.  
*Des Moines, Iowa*

#### RECENT PUBLICATIONS AND CURRENT PERIODICALS

##### DEFENSE

FOUR LOAN PACKETS in a "Nutrition and Defense" series. The Information Exchange on Education and National Defense, U. S. Office of Education, Washington, D.C. Free.

Prepared for teachers. They include pictorial pamphlets on proper foods, suggested teaching units, and guide to governmental and other sources of nutrition education information.

FIRE PROTECTION IN CIVILIAN DEFENSE. U. S. Office of Civilian Defense, Washington, D.C., 1941. 44 pp.

This pamphlet, one of a series for use of instructors and volunteers in training, has good illustrations as well as instructions for fire protection.

STAFF MANUAL, United States Citizens' Defense Corps. The Training Section, Office of Civilian Defense, Washington, D.C., 1942. 8 pp.

This pamphlet should be helpful to public health nurses. It states briefly the responsibilities of members of the Citizens' Defense Corps, and has a list of publications of the Office of Civilian Defense.

FOOD FOR THOUGHT—The School's Responsibility in Nutrition Education. Superintendent of Documents, Washington, D.C., 1941. 15c. (Loan packets on nutrition education available from the Information Exchange, U. S. Office of Education, Washington, D.C.)

This is a report of the U. S. Office of Education on our national and nutritional status. It suggests how schools and communities can provide nutrition education and services.

FITNESS FOR FREEDOM. Survey Associates, Inc., New York, 1942. 40c a single copy, 4 copies for \$1, payment with order.

Many facets of health and fitness in wartime are explored in a special number of the *Survey Graphic*, "Fitness for Freedom," March 1942. Public health nurses will find this issue valuable source of information and guidance in regard to emphases most needed in health programs in the present national emergency.

OUR FUTURE STRENGTH. United States Department of Agriculture, Agricultural Adjustment Administration, Washington, D.C., 1941. No. G-109.

VOLUNTEERS IN HEALTH, MEDICAL CARE AND NURSING. U. S. Office of Civilian Defense, Washington, D.C., 1942.

For use of the executives of civilian defense volunteer offices and executives of agencies using volunteer services in health, medical care, and nursing programs. A handbook on the need for volunteer service in the war emergency, showing opportunities in health agencies for use of volunteers, qualifications and suggested duties, instructions that should be given to volunteers, and a suggested reading list.

SERVICES TO THE ARMED FORCES. The American National Red Cross, Washington, D.C., revised 1941. Free.

# NEWS

## *Highlights on Defense*

### MEETING OF COUNCIL

**G**RAVE PROBLEMS facing nursing today were discussed at the tenth meeting of the Nursing Council on National Defense in New York City on January 21. A progress report was made on the program for recruitment of qualified student nurses to meet the nation's future needs by Katharine Faville, chairman of the Committee on Recruitment of Student Nurses. A report on measures for safeguarding educational standards under wartime pressures was made by Isabel Stewart, chairman of the Committee on Educational Policies and Personnel.

The present policy of the Council to serve as a coordinator of all nursing activities in the defense program and to allocate the execution of plans to member agencies or to the state nursing councils on defense was given a vote of confidence.

Reports to the Council were made by Alma C. Haupt, executive secretary of the Subcommittee on Nursing, Health and Medical Committee, Office of Defense Health and Welfare Services (See page 147) and by Marion G. Randall, nursing consultant, U. S. Office of Civilian Defense.

The methods of training and other problems involved in the use of volunteers in public health nursing services were referred to the National Organization for Public Health Nursing for consideration and planning.

The Council voted that the present chairman and members should serve until the annual meeting in July 1942 following the Biennial Convention, at which time the individual boards will elect representatives of their organizations for membership on the Council. New terms of office will begin at the time of the July meeting. The provision

that the president of the American Nurses' Association shall serve as chairman of the Council was rescinded, and the Council will elect its own chairman at its July meeting. The power to add *ex officio* members to the Council was given to the Executive Committee.

The Council agreed that its committees shall be given adequate funds to carry on their programs, within budget limitations. Possibilities for securing other funds to make possible a necessary expansion of activities were explored.

Authorization was given for the Council headquarters to be moved from the offices of the American Nurses' Association to two rooms of its own at 1790 Broadway, New York City.

An interesting report of nursing problems and program in Canada in wartime was given by Ethel Johns, editor of *The Canadian Nurse*, who was present for the first time at a Council meeting. She said that lines of specialization within the nursing field are necessarily broken down to achieve effective functioning in war; that all nurses must be ready to fit in where they are needed; and that public health nurses must be ready to serve interchangeably in hospital or field. Canada is welcoming and using the assistance of auxiliary nursing groups of all kinds to supplement skilled nursing service in order to meet the country's needs.

### IMPORTANT APPOINTMENTS

**M**ARY J. DUNN, a regular member of the nursing consultant staff of the U. S. Public Health Service, has been placed in administrative charge of its Nursing Education Unit. She succeeds Margaret Arnstein, who was lent to the U. S. Public Health Service by the New

York State Department of Health for a three-months' period ending November 1, 1941. In addition to the various administrative duties involved in her new work, Miss Dunn will assume responsibility for evaluating all plans pertaining to public health nursing and midwifery programs. Lucille Petry and Mrs. Eugenia K. Spalding, working within designated geographical areas, will continue to evaluate plans relative to basic, refresher, and advanced nursing curricula—exclusive of public health nursing.

Miss Dunn has been with the Public Health Service for six years, serving first as regional public health nursing consultant for the southeastern area, and then as assistant to Pearl McIver, senior public health nursing consultant. She has recently been engaged in the preparation of A Curriculum Guide for Public Health Nursing, a joint project of the National Organization for Public Health Nursing and the Public Health Service. This study was presented for approval to the Board of Directors of the N.O.P.H.N. at its annual meeting in January 1942, and was approved. Before going to the Public Health Service, Miss Dunn was associate professor of Public Health Nursing at the Vanderbilt University School of Nursing, Nashville, Tennessee.

Mary O. Jenny has been appointed associate nursing education consultant, U. S. Public Health Service, effective March 1, 1942. Miss Jenny's work will include considerable field visiting in the interpretation of the federal aid program for nursing education.

Miss Jenny is at present instructor of nursing education at Boston University, Boston, Massachusetts. She formerly held positions as instructor of nursing education at the University of Rochester, New York, and associate director, Department of Nursing Education, St. John's University, Brooklyn, New York.

Marguerite Wales has been appointed director of nursing in the Eastern Area of the American Red Cross for a period of six months, during which she is on leave from the W. K. Kellogg Foundation, Battle Creek, Michigan. Miss Wales is nursing consultant of the Foundation. She was formerly general director of the Henry Street Visiting Nurse Service in New York City. Miss Wales succeeded Lucy Massey, who resigned to resume work in the field of nursing education in which she was formerly engaged.

#### NURSE'S AIDE COURSES INCREASE

OVER 5000 volunteer nurse's aides are now in training in the volunteer nurse's aide course sponsored by the American Red Cross and the Office of Civilian Defense. These nurse's aides serve in hospitals, in emergency medical field units, and in public health agencies. The use of their service is one way to supplement skilled nursing service and to relieve the shortage of graduate nurses.

The American Red Cross has been designated by the Office of Civilian Defense as the agency responsible for the training of volunteer nurse's aides and the two agencies have announced as their goal the training of 100,000 aides within the year. The percentage of increase in Red Cross chapters starting the program between December 1, 1941, and January 1, 1942, was 104 percent in the Eastern Area, 50 percent in the Midwestern Area, and 171 percent in the Pacific Area; between January 1 and February 1, 1942, the increase in chapters carrying the program was 54 percent in the Eastern Area, 300 percent, Midwestern Area, 125 percent, Pacific Area.

Colleges are beginning to give this course in cooperation with Red Cross chapters, either as an elective defense course, as at Bryn Mawr College, or as a course with college credit, as at the University of South Carolina and at

Bucknell University. It is hoped that these courses in colleges will stimulate interest in nursing among college girls and thus lead eventually to an increased enrollment of students in schools of nursing. Several aides are already planning to enter schools of nursing.

A class for Negro volunteer aides is under way in Pittsburgh, Pennsylvania, and there are several Negro students in mixed classes in other cities. In some communities the courses are given in the evening for working girls and many of these young women are found to be among the most dependable volunteers.

The use of aides has been endorsed by the Nursing Council on National Defense. The training of these women is one of the most important aspects of the national defense program.

#### CONFERENCE ON EDUCATION

THE CONTRIBUTION which can be made by colleges and universities to the preparation of nurses was discussed in a conference called by the American Council on Education in New York City on January 27 and 28. Among the organizations represented at the conference in addition to the American Council on Education, the National League of Nursing Education, and the Association of Collegiate Schools of Nursing, were the Nursing Council on National Defense, the Subcommittee on Nursing of the Health and Medical Committee, the American Red Cross Nursing Service, the U. S. Public Health Service, the American Association of Junior Colleges, the Association of American Medical Colleges, and the National Association of Deans of Women. Attending the conference and actively participating were the chancellors, presidents, deans, or other executive officers of several colleges and universities. A report of the conference appears in *The American Journal of Nursing* for March.

#### STUDY PROGRAMS RECEIVE FUNDS

FEDERAL funds appropriated by Congress for nursing education (see September issue of *PUBLIC HEALTH NURSING*, page 540) have been allocated to the following programs of study in public health nursing:

##### California

University of California, College of Applied Arts, Department of Bacteriology, Curriculum in Public Health Nursing, Los Angeles

##### District of Columbia

Catholic University of America, School of Nursing Education, Public Health Nursing Division, Washington

##### Illinois

Loyola University, School of Medicine, Department of Preventive Medicine, Public Health, and Bacteriology, Chicago

University of Chicago, Division of Biological Sciences, Nursing Education, Chicago

##### Massachusetts

Simmons College, School of Nursing, Boston

##### Michigan

University of Michigan, School of Public Health, Ann Arbor

Wayne University, College of Liberal Arts, Department of Nursing, Detroit

##### Minnesota

University of Minnesota, Department of Preventive Medicine and Public Health, Minneapolis

##### Missouri

St. Louis University, School of Nursing, Division of Public Health Nursing, St. Louis

##### New York

Columbia University, Teachers College, Division of Nursing Education, New York

New York University, School of Education, Nursing Education Curricula, New York

St. John's University, Teachers College, Nursing Education Department, Brooklyn

Syracuse University, College of Medicine, Department of Public Health Nursing, Syracuse

##### Ohio

Western Reserve University, School of Nursing, Cleveland

##### Oregon

University of Oregon, Medical School, Department of Nursing Education, Portland

##### Pennsylvania

Duquesne University, School of Nursing, Pittsburgh

University of Pennsylvania, Department of Nursing Education, Philadelphia

##### Virginia

Medical College of Virginia, Saint Philip School of Nursing, Richmond

Richmond Professional Institute of the College of William and Mary, School of Public Health Nursing, Richmond

##### Washington

University of Washington, School of Nursing Education, Seattle

##### Wisconsin

University of Wisconsin, School of Nursing, Madison



### *From Far and Near*

• Over two hundred experts will take part in the general program of the Second American Congress on Obstetrics and Gynecology in St. Louis, Mo., April 6-10. The problems growing out of the present shift in medical and nursing services from civil to military duties to meet wartime needs will be given special attention.

The morning sessions will be divided into two periods, from 9:30 to 11:00 and 11:00 to 12:00. The more formal presentations will appear in the first period. A series of "Obstetric Information Please" round tables will be held at 11:00 a.m. each day. During the afternoons, various groups will present formal programs on nursing, public health, and hospital administration, among which will be certain combined programs.

Practical demonstrations are scheduled in the scientific exhibit area on manikin deliveries, home-care technique, and blood transfusions. Nurses planning to attend are asked to send in their registration fee of \$5. Hotel reservations should be made directly, at an early date. Further information is available from the central office of the Congress at 650 Rush Street, Chicago, Illinois.

• More than 500,000 refugees all over the Philippine Islands are being cared for by the American Red Cross. Preparations for any eventuality had been made months in advance of the attack on the Islands, and large stores of emergency medical supplies and first-aid equipment shipped from the United States had been strategically placed. Ten Red Cross first-aid stations of 50 beds each were set up and ready to operate.

In cooperation with government and army officials, the Red Cross last summer had rehearsed a plan for evacuation from bombed areas. Communities with adequate water supply, sanitary and transportation facilities, and housing and

feeding resources had been prepared. The Philippine Red Cross had organized over 100 trained disaster relief workers, and 120 volunteers who had been trained in first-aid and other emergency service. More than 400 trained members of the Junior Red Cross were also ready for action. Thus the islands were ready to give immediate care to casualties and refugees when the attack occurred.

• Shirley C. Titus has been appointed editor of the *Pacific Coast Journal of Nursing* and executive secretary of the California State Nurses' Association. Miss Titus, who is a native of California, was for many years professor of nursing education and dean of the School of Nursing of Vanderbilt University, Nashville, Tennessee—a Rockefeller Foundation project for curriculum experimentation in the integration of health in the basic curriculum. She has held important administrative, educational, and public health positions in various parts of the country and is a member of the Advisory Committee on Public Health Nursing of the U. S. Children's Bureau. Congratulations and best wishes are extended to Miss Titus and to the *Journal*.

• The annual convention of the National Education Association will be held in Denver, Colorado, June 28-July 2, 1942.

• The Subcommittee on Nursing, Health and Medical Committee, Office of Defense Health and Welfare Services, has moved to 601 Pennsylvania Avenue, N.W., Washington, D.C.

CORRECTION: The public health nursing curriculum of the University of California at Berkeley is now (and has been since last spring) located in the School of Nursing and not in the Department of Hygiene as stated in the Official Directory of Public Health Nursing, January 1942 issue of PUBLIC HEALTH NURSING, page 67. All inquiries should be addressed to Dr. Merton C. Hill, Director of Admissions.

### Board Considers Wartime Needs

(Continued from page 164)

ships between the professional nursing organizations and governmental defense agencies as carried out through the channel of the Nursing Council on National Defense. She believes nurses have gone further than other groups in using the services of volunteers. She thinks, however, that their use can be still further extended. She mentioned the follow-up services which will be expected of public health nurses in case of incidents caused by air raids or sabotage. If they are familiar—through recent first-aid courses—with the dangerous symptoms which may follow injuries,

they can be of great help in visiting patients who are sent home after supposedly minor accidents.

Miss Haupt closed the discussion by stating her strong feeling that the next six to twelve months are the crucial period for all of us, and that everything should be considered in relation to the need for prompt action. She believes the N.O.P.H.N. can assume leadership in helping public health nurses to fit into the emergency medical program and at the same time continue essential parts of their own former programs.

RUTH HOULTON, R.N.

General Director, National  
Organization for Public Health Nursing

### First Line of Defense

(Continued from page 159)

School children who are given this information in first-aid classes may carry the message home to their parents, but what about families where there are no children of school age? Does the public health nurse think to teach them measures for prevention of infection? The layman is inclined to wash wounds with water before applying tincture of iodine—whereas only in the case of an animal bite is this the thing to do. Specific instructions for the care of all skin injuries are needed by many adults and will be welcomed by them.

The proper care of wounds is of major importance in industry. The nurse in industry is, however, interested not only in the workers at the plant but in their families too, realizing as she does how the welfare of the workers is affected by that of the folks at home. Can she not do a great deal to help promote health by teaching employees the value of safe-

guarding the skin, which is the first line of defense?

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# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## Adjustments to Wartime Changes

**M**ANY public health nursing agencies have already been profoundly affected by the war. Some have given nurses to the military services or to the U. S. Public Health Service for assignment to defense areas. Agencies located in such areas have expanded or modified programs to meet changing needs. Most organizations are facing difficulty in securing needed supplies; some have been unable to get tires for nurses' cars, or new automobiles to replace old ones.

Agencies which have not yet felt the pinch in personnel, program, or equipment know that changes are inevitable and that advance planning is necessary if adjustments are to be made without sacrifice of vital community service.

Requests to the N.O.P.H.N. for help increasingly revolve around these new or anticipated wartime adjustments. What is being done to assist agencies and nurses in meeting new conditions? How can they receive information and guidance in making unprecedented decisions? How can they keep abreast of the rapidly changing national nursing picture and its relation to their work?

Especially important in the light of these new needs is the Biennial Convention to be held in Chicago, May 18-22. Adjustments which must be made in the lives and work of us all to carry on the task that lies ahead will be the recurring theme in these meetings. The program will be extremely practical, built around the new situations which agencies are facing. Old problems that are still with

us are not neglected—tuberculosis and syphilis and maternal health. But discussions will revolve around careful planning for efficiency and economy to replace wasteful methods which sometimes survived their usefulness in peacetime but which cannot be tolerated in today's crisis, with diminishing civilian nursing service and increased needs. Emphasized throughout will be new adjustments—in education, supervision, and distribution of public health nurses, in program, in administration. Arrangements to attend the convention may be more difficult than ever before; but it has never been so important as this year.

**T**HE STAFF and committees of the National are keenly aware of the needs of the field at this time. Their work is being geared to a country at war. They are closely in touch with developments both in national planning and in local communities. The work of N.O.P.H.N. committees, drawn from representative agencies in all parts of the country, has always been a source of guidance and help to public health nurses; today, when we are facing changes more drastic than at any time in our history, the activities of these groups are intensified and speeded up. For example, the article on "Wartime Economies in the Use of Cars" (page 183) represents the collaboration of a subcommittee of the Committee on Nursing Administration and a staff member in rapidly gathering together material which may be of help to agencies or nurses in planning for trans-

portation under wartime restrictions.

In addition to the leadership of representative national committees, the exchange of experiences of individual public health nurses throughout the country comprises one of the chief values of a national professional organization. Thus, the patterns which are being tried or have proved successful may be used with adaptations by other nurses to meet similar conditions or to avoid similar pitfalls.

An important channel for the sharing of the work of national groups and the experiences of individual agencies and nurses is found in the professional magazines, whose pages give a continuous story of the changing scene in nursing and the organization of our resources to meet the emergency. Three writers share experiences with us this month. Hawaii has already undergone war, and the part played by its public

*(Continued on page 182)*

### THE N.O.P.H.N. IS OUR "MAN FRIDAY"

IT IS DIFFICULT for most of us to evaluate that which we have. I am reminded of a story from *Coloured Lands* by Gilbert K. Chesterton, which runs something like this: A little boy, Tobias Theodore, is pictured sitting on his bright green, tree-shaded lawn, looking wistfully beyond his white house with green shutters—to greener fields. Suddenly a wizard appears and gives him colored glasses of different shades to look through. The wizard then puts before Tobias tubes of colored paints, and tells him to paint the world that he would really like. Tobias seizes the brush and paints with zest. The finished picture shows a cozy white house with green shutters, on a bright green, tree-shaded lawn.

We all love to complain but we all know in our heart of hearts that our National Organization just about suits us. The N.O.P.H.N. has acted as our "Man Friday" for the Family Nursing Service. When the question of a name for our new organization arose we wrote to the National. We received an immediate response, and a name was selected. Sample drafts of articles of incorporation and bylaws were sent within twenty-four hours after we requested them—with recommendations

which prevented mistakes that had been made by other organizations.

When the Community Chest raised the question of tax support for private nursing organizations we turned to the N.O.P.H.N. to find what the trend was and to what extent tax support was being given to private agencies. A reply was received as quickly as the mails could deliver it.

Again we wrote to the National to verify the fact that visiting nursing organizations were employing nutritionists on their staffs. We wished to know what specific organizations were employing them, how many, and for how long a period of time. This was done to prove to a sceptical Community Chest Board that the St. Paul Family Nursing Service, in asking for a nutrition worker, was not launching a service that did not belong to its field. A nutrition worker on a part-time basis will be on our staff for 1942.

Thus runs the story of what the N.O.P.H.N. has meant to us as a growing public health nursing service. It has proved a ready source of authoritative information and is recognized as such by lay and professional groups.

GERTRUDE LYONS, R.N.

*Director, St. Paul Family Nursing Service  
St. Paul, Minnesota*



# Public Health Nursing in Hawaii at War

By VIRGINIA A. JONES, R.N., AND MILDRED D. BYERS, R.N.

**R**ADIO Stations KGU and KGMS on Sunday morning, December 7, 1941: "Civilians stay off the streets! Civilians stay off the streets! All army, navy, marine, and first-aid station personnel report to your stations at once! All firemen and policemen report to your stations at once!" Repeated. Repeated. Guns—explosives—the sound of many planes overhead. A few bars from the New York symphony. "This is *real*. Oahu is under enemy attack. Planes with the insignia of the Rising Sun have been sighted over Oahu." An announcement in Japanese: "Stay at home. Keep calm. Do not use your telephone. You are hindering the army."

With our radios telling us these incredible things and giving us these stern instructions, we were torn trying to decide whether this was a superb practice raid or whether we should believe that the impossible had happened. However, for more public health nurses reality and believing came rapidly. Our telephones began to ring asking us to place ourselves in readiness for immediate call, or to report to duty at once. These were necessary calls, so they were allowed through the switchboards.

A small staff of six nurses was requested to report to the Board of Health building in Honolulu for the remainder of the day, and a night staff was planned. During that impossible day, we set up a simple first-aid station in a safe place in the basement of the building, and ran the sterilizer until we felt adequately equipped. Many of our doctors and men from the Bureau of Sanitation were in the building all day. We watched an aerial battle from our windows, and could

hardly tear ourselves away from the radio, which ceased broadcasting early in the afternoon except for army announcements to civilians.

In the meanwhile, members of the staff on all islands, as well as public health nurses who were not members of the Board of Health staff, were being called for service, and were volunteering in innumerable places, such as hospitals and the previously organized medical-aid stations. Calls for volunteer nursing services were being received by the Nursing Service Bureau in Honolulu, and it was largely through this medium that nurses were made available where they were most needed. In the city of Honolulu public health nurses were sent to Tripler General Hospital, to the large army base hospital at Honolulu, and to the United States Naval Hospital at Pearl Harbor. One of the nursing students at the University of Hawaii was sent to the hospital ship *Solace*. Other public health nurses were being called or were volunteering for service in the medical-aid stations.

## RURAL NURSES MEET THE EMERGENCY

Rural Oahu public health nurses were to be found in all the rural first-aid stations and rural hospitals, and were organizing and setting up new stations in areas where none had been previously set up.

One Oahu nurse who gave volunteer service in a rural hospital located very close to the major combat area described her first night as follows:

It was a strange experience indeed, working through long, black hours with the feeble assistance of blue-covered flashlights which cast a weird light on the faces of men already

made almost unrecognizable by charred flesh and the purple coloring of gentian violet; hurrying up and down corridors; sneaking in doors to prevent the escape of dim light from heat cradles; feeling for feeble pulsations in temples or wherever flesh was intact. It was most gratifying to give service so sorely needed and so welcomed by the men. The only natural part of the strange night was the intermittent crying of babies in the nursery at times when they felt that they were entitled to food regardless of bombings.

Later, when letters reached us from the outside islands, we learned that their public health nurses had been doing much the same thing as Oahu nurses—reporting to hospitals and stations, and assisting with the setup of new stations. All held themselves in readiness to give service at any hour, in any place where they were needed. Board of Health nurses were later asked to report in writing what they had been called upon to do during the first few days until they could be relieved to return to their regular duties. These written reports give a picture of color, drama, and action that is now a page of our history. They give word pictures of the people, their emotions and fears, their splendid eagerness to be of help, and how they looked to the familiar blue figure of their district nurse for leadership and reassurance.

Not all accounts are as dramatic as this one by a nurse in a rural district, but it illustrates the spirit of the people and the manner in which the nurses turned to any needed activity, however unaccustomed:

In the early evening on December 8, when things were more organized and the road declared safe for travel by the police—who won't, however, be responsible for accidents—I started out to visit two expectant mothers who were due to deliver soon. I arrived at the first home to find that the woman's brother was reported killed the day before. On the steps I was greeted by a neighbor who was widowed by the raid. Everyone looked sad but managed to smile when I entered.

"It can't be helped, we must all work

together," said the widow as she hurried about to help me. I found the woman in labor with head engaged and membranes intact. The family could not get a doctor since everyone was busy with the injured. I took from my bag the sterile gloves, cord tie, and cord dressing. A kettle of boiled water was ready. I put on another kettle, put the scissors to boil, and sterilized a basin. A male infant was born at 3:25 p.m. without any difficulty. The placenta was delivered five minutes later. After everything was put in order, the baby was shown to the grandfather. Grandmother remarked, "We have lost a son but gained a *moopuna*"—Hawaiian for grandchild.

#### WE WERE PREPARED

Public health nurses in the territory had been preparing for just such an emergency. Their staff-education program had centered around the care of mothers in emergency, delivery service in the home, and care of the premature infant. Incubators and equipment for the care of a premature baby born at home had been prepared and placed in readiness for immediate use at any time in the twenty-four hours. The communicable diseases which might assume increasing importance under wartime conditions had been studied, as well as mass immunizing procedures. The nurses had been given an opportunity to practice the techniques of mass immunization when all members of the Board of Health staff were immunized against typhoid and paratyphoid fever and smallpox.

In all areas, the nurses were called upon to exercise powers of organization, leadership, ingenuity, and understanding. No one hesitated because what seemed necessary was not strictly nursing. One rural nurse reported:

We set up a first-aid unit in the new fire station. Supplies and equipment were begged, borrowed, and stolen from the dispensaries of two large industries and the Board of Health office. The equipment for the fire station had arrived so we set up eight of their beds and mattresses. The first day and night passed with a great deal of confusion. The aid station being in a concrete building, many people

crowded in for protection against bombs. Several spent the night, while others would stay a while and then get a guard to take them home. The first night we had three alarms, with some artillery firing each time. In the early part of the day, the Salvation Army set up a coffee and doughnut station in the kitchen of the fire station.

Hundreds of men who were on guard or on special duty were coming in for refreshment. The air became foul with the odor of wet clothing beginning to dry on hot, sweaty bodies, mingled with the odors of frying doughnuts and hot coffee and cigarette smoke. Paper cups, particles of food, and cigarette butts were thrown on the floor, in the sink, and in the drinking fountain. At midnight, I suggested that the kitchen be cleared of people and cleaned up by some of the loiterers. This was done. All the lights were put out and the place given a good airing. After this only a few people were allowed in the kitchen at one time.

Monday was spent in organizing the hundreds of volunteers who were asking for something to do. I started to interview the first comers when I realized that this was something someone else could do. There were so many volunteers and so little for them to do that we decided to start first-aid classes for them.

When I visited a maternity patient, I found she had attempted to black out her room for a home delivery. Knowing the rigid rules for blackout I was sure it would not get by. I mooched some black paper from the home defense office so that the husband could do a finished job.

Because many restaurants were closed completely and all have to close at 4:00 p.m., many women were put out of jobs. The situation was developing into a serious problem. I went to the captain of the police, and he suggested that I see the engineers' department. Fortunately, they could use women to load gun belts at Schofield Barracks. For the time being the problem was solved.

When more order came out of the chaos, classes in home nursing and first aid and classes for nurse's aides were organized and taught by public health nurses, with the help of hospital and first-aid-unit staffs. All the Board of Health nurses for months had been spending hours of off-duty time brushing up on first-aid procedures and preparing to teach. When the emergency came, they were often found to be the only available

ones in their communities prepared to give instruction.

Leaflets distributed by the Board of Health, suggesting island foods which could be substituted for less available foods, had not seemed so important until all shipments of food from outside had been cut off.

"It was surprising," said one nurse, "how many people got out their island food leaflets and in the emergency felt they were a great help. A great many people, many of whom had never come to us before, were appreciative of the help we were able to give."

Another nurse remarked:

I had seen many of our mothers and families around the aid stations and had taken the opportunity to caution them to keep children in and quiet, and to warn them about the danger of the children's becoming ill more easily with all the excitement. Later, I was in one of the neighborhood camps and asked whether anyone was ill. They answered, "No, we know you have enough to do without taking care of our children. We are staying at home and keeping them well."

#### PROBLEMS OF EVACUEES

A great many mothers, children, and aged persons were immediately evacuated from zones of great danger to schools and private homes. These people in particular—who were not only as disturbed and shaken as all of us but were in addition homeless, separated from husbands and fathers, with responsibility for infants and young children—were in acute need of the assuring, calming presence of the public health nurse. She assisted with the innumerable problems of comfort and safety which must arise when large groups of people are suddenly obliged to live together in buildings which were never intended to be homes. A rural nurse wrote:

On Tuesday, many complaints were coming in to the nurse about unsanitary conditions, diarrhea, and dysentery among the evacuees. Six of the homes where evacuees were housed were visited. Nothing more serious than per-

sonal disagreements, slight hysteria, and nervousness among the women and children was found.

Nurses' cars began to take on the aspect of lumber trucks, with rear seats and storage spaces holding improvised splint materials. Bags bulged with extra sterile dressings, triangular bandages, and packages of soda. Headlights on all of our cars were properly painted with the prescribed black and blue paint, in case we should be called out at night. We have all been fingerprinted and enumerated, and we have been issued more passes and cards than our purses hold. We have made up a supply of sterile obstetrical packs for home deliveries, and we have a supply of kerosene lanterns, painted blue, for the use of nurses who may have to be out at night for a home delivery, or for care of a premature infant. We have organized our staff for night call, so that we do not all need to be on call at all times.

In the first few days following the attack many patients were evacuated from the civilian hospitals in Honolulu to provide beds for anticipated casualties. A large number of ambulatory patients were also evacuated from the large city tuberculosis sanatorium. All of these patients and many from the general hospitals were placed under the home supervision of the public health nurses. This evacuation placed a heavy responsibility on the public health nursing service because many of the patients required very close follow-up and would under ordinary circumstances have re-

mained in the hospital for some time to come.

At the present time the Board of Health is carrying out an army order to immunize all civilian residents of Oahu against typhoid and paratyphoid fever and smallpox. This is requiring teamwork with the Bureau of Communicable Diseases, the Department of Public Instruction, the Medical Corps of the army, the Bureau of Public Health Nursing as well as other Board of Health personnel, and the public. The program is progressing even better than we expected, and we are all realizing the pleasure of well organized teamwork. The city nurses especially enjoy the work because it gives them an opportunity to see the country, which few of us have seen since December 7 because of our strict gasoline rationing.

What special contributions did the public health nurses make in those first few harrowing days? What special skills are making them indispensable in these trying months? Above all, the reassurance of their presence doing the familiar things, their sustained interest in the universal problems of mothers with children, their calm presence in the maternal and child health conferences (while all of the time adapting their skills to meet new conditions of blackout, curfews, gasoline and tire rationing, closed schools, the difficulties of securing the accustomed food), their understanding in the face of fear, insecurity, and racial prejudices—these were and are their special contributions.

### Wartime Changes

*(Continued from page 178)*

health nurses on December 7 and afterwards shows the adaptability which we will all need in this emergency. Changes made or planned by public health nurses working in the schools are discussed in two articles in this issue.

Many difficulties lie ahead of us, but

none of us is working alone. At our Biennial Convention, through the professional magazines, through other channels, opportunity is afforded for the sharing and discussing of new ideas and new methods now on trial, for help in pioneering in the new roads which we must all learn to travel in the months ahead.

P.P.

# Wartime Economies in the Use of Cars

By HORTENSE HILBERT, R.N.

Timely and practical is this article giving information on rationing of tires and cars, suggestions for economies in their use, and pointers on travel studies

**I**N VIEW of the wartime necessity for conserving automobiles and tires, public health nursing agencies and nurses everywhere are seriously concerned with such modifications in their transportation practices as will result in the necessary economies with the least possible curtailment in essential health services.

In this connection, tire rationing is a subject of immediate interest. Responsibility for rationing of tires rests with the U. S. Office of Price Administration. The introduction to its pamphlet on Tire Rationing Regulations states that the OPA has been "delegated the function of distributing the very limited supply of rubber tires which can be made available for civilian uses among those persons and enterprises which must be assured transportation if the community is to remain safe, healthy, and productive."<sup>1</sup>

The Far East has been the source of 98 percent of our rubber, explains this introduction, and due to interruptions in communications and the "scorched earth policy" resulting from the Japanese attack, the Far East will probably be eliminated as a source of rubber supply for a long time to come. We must, therefore, rely for several years ahead on the "stock-pile" of rubber now on hand in this country.

Nurses engaged in certain kinds of service are among those designated in the eligibility classification for tires and tubes according to these Tire Rationing

Regulations. The sections of the regulation that apply to eligibility of nurses are as follows:

Chapter IV. Tires and Tubes for Vehicles Eligible under List A—Section 405—Eligibility Classification:

(a) A vehicle which is operated by a physician, surgeon, visiting nurse, or a farm veterinary, or which is used principally for professional services.

(ii) For the purposes of this subsection, "visiting nurse" shall mean a nurse who is employed by a clinic, hospital, government agency, or similar organization or by an industrial concern to make nursing or inspection calls for such agencies. The term "visiting nurse" does not include private nurses.

(iii) No certificate shall be issued unless the physician, surgeon, nurse, or farm veterinary applying shows that the particular vehicle on which the tire or tube is to be mounted is actually used for professional calls and is used principally for that purpose.

Further clarification of this subsection relating to a definition of "visiting nurse" has been suggested by the National Organization for Public Health Nursing, as follows:

For the purposes of paragraph (a) above, "visiting nurse" shall mean a nurse who is employed by a governmental agency such as a board of education or a board of health, a non-governmental agency such as a visiting nurse association or a public health nursing association, or an industrial concern, whose duties require her to make regular nursing or health inspection visits to homes, schools, or clinics, and who needs and uses a motor vehicle to make them.



#### RATIONING BOARDS APPOINTED

State rationing administrators have been appointed in every state, in cooperation with state defense councils. Wherever the size of the community and the number of automobile registrations warrant, a local rationing board is set up in cooperation with the local defense council. A local board may serve a county, a single community, or several communities. The defense councils are created either by governor's order or by statute, thus giving the rationing boards official status.

Issuance of certificates to persons eligible for tire rations is the responsibility of the local rationing boards. The rationing system is set up on the basis of quotas, which are determined by the number of automobile registrations in a given community and the "requirements" of the community. Certain discretionary powers in regard to carrying out the rationing regulations issued by the federal Office of Price Administration are exercised by the local rationing boards.

Quotas are set for tires to be rationed by local boards. The regulations state that: "The Office of Price Administration shall fix quotas stating the maximum number of new tires and tubes and retreaded or recapped tires for the purchase of which certificates may be issued by Boards during a single calendar month. No Board shall issue a certificate for the purchase of a new tire or tube or a retreaded or recapped tire in excess of its quota."<sup>2</sup> (Supplementary data on issuance of certificates by Boards is given in *Victory*, February 24, 1942.) Application for eligibility for tire and tube rations is made by the individual who considers himself eligible, on a form designed and provided for that purpose by the Office of Price Administration.

It would seem advisable for public health nursing agencies to establish con-

nections with their state or local rationing boards as early as possible in order to receive and contribute whatever information is needed for mutual clarification.

#### RATIONING OF AUTOMOBILES

Some public health nurses and some nursing agencies are of necessity concerned with the problem of replacing old cars. Regulations that apply to the rationing of automobiles were issued by the Office of Price Administration on February 22 and went into effect on March 2. "The list of eligible purchasers in the automobile rationing regulations," according to an official statement issued on February 24, "is virtually identical with the operators of eligible vehicles under the new and retreaded tire rationing plan. Qualifying the broad list of eligible buyers is a set of stringent tests which the local boards must apply before issuing purchase certificates. Briefly, these tests require an eligible applicant to prove his need for a new passenger automobile, in the light of conditions peculiar to his locality."<sup>3</sup>

Responsibility for the rationing of new passenger automobiles, like tire rationing, is given to local rationing boards, under the supervision of state rationing administrators.

Many on the eligible list will be unable to procure new automobiles, it is pointed out by the Price Administrator, because less than 10 percent of last year's automobile production will be available for sale during the next twelve months.

#### GASOLINE

Whether gasoline is to be rationed in the near future is a question frequently asked by nursing agencies. Rationing of gasoline had not yet gone into effect when this was written. However, a press notice on March 17 lists six classes of motor vehicles for preferential treatment. The first comprises "vehicles and boats necessary for public safety, in-

cluding ambulances and vehicles operated by physicians, surgeons, nurses, and veterinarians."

#### USE OF CARS BY VOLUNTEERS

In many communities volunteers contribute the use of their automobiles as well as drivers' services to public health nursing agencies for transporting patients to and from clinics, hospitals, and health centers. This service is admittedly of great value to the community, and will be even more important in the future when less families can furnish transportation themselves. Whether consideration will be given to rationing of automobiles or tires for voluntary services of this kind remains to be seen. If not, some public health nursing agencies may need to consider the purchase of additional cars which can be driven by volunteers. Some public health nursing agencies in which transportation of patients constitutes a significant service have considered the purchase of station wagons for that purpose.

#### PROPER CARE OF AUTOMOBILES

The major emphasis in conservation of automobiles and tires by public health nursing agencies and nurses should unquestionably be placed upon their careful use. Suggestions in regard to the proper care of cars and tires to increase their longevity and to reduce maintenance costs are available from various governmental and commercial sources. Owners' manuals provided by manufacturers with each car are recommended because of the detailed information they contain in regard to care of cars of specific makes.

From the Office of Price Administration comes some timely advice for motorists under the caption "Take Care of Your Tires." It is pointed out that the first way to save on tires is to eliminate unnecessary use of cars. Ten ways to lengthen the life of tires are listed, as follows:<sup>4</sup>

1. Drive at moderate speeds. Your tires wear out twice as fast at 60 as they do at 35.
2. Use your brakes with care. Jamming brakes and fast starts are sure to scuff the tire, leave precious rubber on the road.
3. Take curves slowly. Your tires and you will both live longer.
4. Look out for bumps. Stones, ruts, and rough roads are tough on tires. Bruising and scraping against the curb are bad medicine.
5. Keep your tires properly inflated. See that the air-pressure recommended for your tires is always there. Check the pressure at least once a week. A pound or so too much air is better than not enough. Check valves to prevent leakage.
6. Keep your brakes equalized. Unequal braking shortens tire life by causing unequal wear.
7. Keep your wheels aligned. Wheel alignment should be checked every six months.
8. Cross-switch your tires. Wheel-to-wheel changes help tires wear longer. Shift them every 5000 miles, keeping the spare in use.
9. Repair promptly. Cuts, leaks, breaks, and bruises need quick first aid to prevent permanent damage.
10. Keep your car and tires under cover as much as possible. Sun and air ruin rubber.

Additional advice is offered by The B. F. Goodrich Company in its "Twelve Rules for Tire Health," as follows:<sup>5</sup>

Whenever you put on a new tire, or whenever a tire has been off the rim, do not start on a long drive with implicit faith that its air pressure is correct. A tire may lose several pounds of pressure immediately after it is put on the rim. Have it checked a few miles down the road.

Do not rely on the generally accepted theory that it is all right to run old tires on back wheels, because a rear tire blow-out is supposed to be less dangerous than one in front. A rear tire blow-out is every bit as dangerous.

Do not drive too fast on hot, dry roads. In extremely hot weather on dry roads, high speeds heat the tires and hasten deterioration.

Start up gently, do not spin your wheels.

A list of suggestions which apply to other parts of automobiles as well as tires has been provided by the Fleet Sales Division of the General Motors Corporation, through its New York resident manager. They are quoted here in slightly condensed form, with his permission:

*Battery and electrical equipment*

See that the battery always contains sufficient water to cover the plates. This should be checked at least once a week in the summer and once every two weeks in winter—oftener, if on a long run.

Don't add water in winter unless you are about to drive the car, so that the water can mix with the solution; otherwise the water will freeze.

See that battery terminals are kept free from corrosion. A coating of vaseline on terminals will prevent this.

See that all electrical connections are tight. Watch the instrument board occasionally to see that connections are functioning properly.

See that spark plugs are clean and the gap is properly set. It is a good idea to have them checked every 3000 or 4000 miles and to replace them every 10,000 miles if possible.

*Air cleaner*

The air cleaner and intake silencer should be removed and cleaned every 2000 miles—more often if car is operated in extremely dusty conditions such as on dirt roads. This can be done at the place you buy your gasoline.

*Gasoline economy*

Assuming that the car is functioning normally, gasoline economy is up to the driver.

Don't drive fast. At speed over 40 miles an hour, gasoline economy drops rapidly.

Don't jiggle the accelerator pedal while waiting for a stop light.

Don't try to be the first one away when the stop light turns. This uses considerable gasoline and causes unnecessary strain on the clutch and all the driving mechanism.

See that the spark is advanced as far as possible with reference to the type of gasoline used.

Don't drive further than necessary in low gear. Get to high gear as soon as possible, because the engine is running slower in proportion to car speed when in high gear.

Don't let the engine idle for long periods when standing.

*Oil*

See that the oil in the crankcase is changed at proper intervals—normally, 2000 to 3000 miles after the first change at 500 miles. (See the car manufacturer's instruction book for its recommendation on this point.)

Make sure that the oil is drained while the engine is hot; otherwise sediment in the oil will settle to the bottom of the crankcase and will not be drained out. When the engine is hot, sediment in the oil is in suspension and will flow out with the oil.

Use the proper grade of oil as recommended

by the car manufacturer and see that the oil is always at the proper level.

**TRAVEL STUDIES**

It can be said without reservation that automobiles are indispensable for carrying on public health nursing services in rural areas. In communities where the population is more concentrated, automobiles may or may not be absolutely essential for every nurse in every district.

Periodic studies of travel in districts served by public health nurses, which have been considered necessary in pre-emergency days, are now of special significance in a war economy where professionally trained nursing personnel, automobiles, and facilities needed to operate cars are all at a premium. In determining travel requirements, economy of energy and strength of the public health nurse is a factor equally as important as economy of her time for more service and economy in agency expenditures for travel.

Studies of travel in the nursing service of the Metropolitan Life Insurance Company have been made by its Welfare Division. Some information and opinions—heretofore unpublished—growing out of these studies have been generously contributed by Thomas W. Scott, manager of the Division. Although the studies of travel that have been made by this Company relate to visiting nursing, the suggestions are equally pertinent to other types of public health nursing service:

The use of a car by a nursing agency in a district that can be satisfactorily covered either by walking or by means of a bus or street car is contrary to the interests of the agency and of the government conservation program. Undoubtedly nurses are today using cars in districts that do not require them. On the other hand, there is perhaps no other single greater waste of nurse power than to have a public health nurse cover by foot a district which requires a car.



How can we decide whether a car is actually necessary? Perhaps the first thing to do is to review critically the district map. The district may have been laid out some years ago and shifts in population and other changes may have taken place while the boundary lines of the district have remained unchanged. The first step is to look at the map and determine whether the districts are satisfactory. Preparing spot maps of cases carried is a helpful means of determining district boundary lines. Such obvious errors as having a cemetery or a park in the middle of a district or having districts bisected by main arteries carrying heavy traffic should be avoided. Districts should be laid out with a view to making all of them "walking districts," in which the nurse is able to make her visits by walking or by using local means of transportation. Although such districting may not always be possible, an attempt should be made to achieve it.

The location of the main office should also be re-examined. Is it located near the districts, or could more "walking districts" be created if the main office were moved?

Could the transportation situation be improved by creating substations?\*

Frequently substations permit the creation of additional walking districts and the cost of the substations is more than offset by the decrease in transportation cost and the increase in service.

#### IS CAR NECESSARY?

When the agency has satisfied itself that the districts are laid out efficiently and that no change in the location of the main office or the substation is needed, it should then determine whether a car is necessary in each of the districts. In

\*"Substation" may apply to any center from which the nurse works in her district. The type of substation will depend on the type of public health nursing service under consideration. It might be, for example, a health center or a school.

cities or other communities of concentrated population, the well laid out district requires an average of no more than eight minutes' walking or driving time between cases. If the walking time is greater than eight minutes, the need for a car seems to be indicated. If the driving time is greater than eight minutes, a readjustment of the district seems to be needed. This general rule of course applies only to areas of concentrated population.

It is suggested that the problem be studied for four weeks. During the first two weeks, the nurse should walk about her district or use such local transportation as is available. During the next two weeks, she should cover the district by driving. During both periods she should record the exact travel time between cases. During the two weeks in which she is driving, it is suggested also that the mileage between cases be recorded. For convenience the last three numbers on the speedometer can be recorded. When the record forms are turned in, the difference can be subtracted to indicate the mileage between visits. These record sheets are then summarized to get the average mileage per case for each district during the two-weeks' period of driving.

It is also advisable that the record be critically reviewed to ascertain whether the nurse is routing herself to the best advantage in the district. Certainly the quality of service cannot be sacrificed merely to produce a more efficient route, but if each nurse will give some thought to routing herself most efficiently, much time can be saved.

In addition to the review of the travel forms suggested above, the number of visits made by the nurse in the two weeks when she was walking should be compared with those made in the two weeks when she was driving. Here again it is not always possible to make a significant comparison unless some professional judgment is applied in determining



whether the case load in the first two weeks was more time-consuming than that of the second two weeks.

A critical and unbiased review of this problem may lead to a reduction in the number of cars without any decrease in the efficiency of the organization—an economy which would be of tremendous importance at this time.

The form used by nurses of the Metropolitan Life Insurance Company to report automobile mileage for purposes of travel studies is reproduced here.

It should be added that a study of nursing districts and travel obviously cannot be made independently of a study of case loads and services.

At a time when the need for public health nursing is expanding and personnel and equipment need to be conserved, we look with new interest and

respect upon all possible energy-, time-, and material-saving methods that are consistent with service of good quality. The necessity for realistic appraisal and determined action has never been greater. As a consequence, public health nursing may come through with sound improvements in administrative method not only for the present emergency but for the future.

<sup>1</sup> Office of Emergency Management, Office of Price Administration. Tire Rationing Regulations (Revised), February 19, 1942. Establishing a Program for Rationing Tires and Tubes, Retreading and Recapping of Tires and Camelbacks. Washington, D.C.

<sup>2</sup> *Ibid.*

<sup>3</sup> *Victory*, Official Weekly Bulletin of the Agencies in the Office for Emergency Management, February 24, 1942, pp. 1, 15.

<sup>4</sup> *Consumer Prices*, Consumer Division, Office of Price Administration, January 15, 1942, p. 8.

<sup>5</sup> The B. F. Goodrich Company, Public Relations Department, Akron, Ohio.

## N.T.A. HAS FIELD WORKER FOR NEGRO PROGRAM

OUTSTANDING among the Negro nurses who are making an important contribution to the health of their race is Leola M. Franklin, field worker on the Negro program of the National Tuberculosis Association. Miss Franklin works with state and local tuberculosis associations in their programs for control of tuberculosis among Negroes. She was born in Texas and was graduated from the School of Nursing of the Homer G. Phillips Hospital in St. Louis, Missouri. She took postgraduate work in public health nursing at Teachers College, Columbia University, on a Julius Rosenwald Fund scholarship; was a member of the staff of the St. Louis Department of Public Welfare for eight years; and worked on the joint program of the Milwaukee Visiting Nurses Association and the Wisconsin Anti-Tuberculosis Association for two years.

Her appointment to the staff of the National Tuberculosis Association was



confirmed by the Committee on Negro Program of the Association.



Students take great pride in their school garden, which is a physical education project

## Vocational School Prepares for Emergency

By RUTH V. BIEN, R.N.

OUR GIRLS' vocational school is particularly well equipped for emergency defense service because all its activities are a part of real life situations and the students are already doing or preparing to do things which are vital to defense. Every part of the students' learning experience is a real—not an artificial—activity necessary to our daily living in the school and community.

The 250 students in the Middlesex County Girls' Vocational School, Woodbridge, New Jersey, come from all parts of the county. Many of them travel two hours on the road coming to school. Those who must start very early in the morning have only a light breakfast at home and get a full breakfast at school. This is made available whether or not they can pay for it, and no distinction

is made between those who can pay and those who cannot.

The health program, like every other part of the curriculum, is one of student participation throughout. The health personnel consists of a part-time physician; a full-time public health nurse, who also teaches several classes; and the physical education, home economics, and commercial foods instructors—all of whom are vitally interested in the health program. Physical examinations are made before admission to the school, and the follow-up to secure corrections of defects is done through the public health nurse in the local community where the student lives.

The program for first-aid treatment of students with accidents and illness is carried on through the participation of students in the two-year nursing at-

tendant class, which is taught by the nurse. These students—whose program is described later—serve alternately as “nurse for a day” during their senior year, giving first-aid care as needed, under the nurse’s supervision. This responsibility is taken very seriously by the students, and serves as an excellent learning experience. The entire health service is of course recognized as an important part of the wartime program to keep our people in the best possible health.

Plans for adjustment of the school work to meet emergency needs was begun in May 1941 when President Roosevelt declared a national emergency. At that time the school took stock. Each class considered its particular abilities and potentialities and the contribution it had to make. The girls responded enthusiastically. Work was reorganized and reports made. During the period from May to December 7—when Japan attacked Hawaii—much was accomplished in increased production and morale. Over four hundred dollars worth of defense saving stamps were sold, and mem-

bers of the faculty served as blood donors.

Then war was declared. Instead of consternation, renewed determination was expressed by every student and by members of the faculty to use every facility at hand.

The school is strategically situated in the center of the industrial section of the county. It is easily accessible. All equipment with the exception of that in the power machine department is movable. Rooms can be emptied in a very short time.

#### USE OF SCHOOL FOR HOSPITAL

Because of the plan of the building, the qualifications of the faculty, and the skills of selected students, the possibility of using the school as a defense hospital unit was discussed. The probability of epidemic or disaster is not as remote as we may wish. Hospital beds are scarce. With this in mind and the desire to be actively prepared, the faculty of the school has made a detailed plan for the use of the building and staff as an emergency hospital unit.

Sewing on the school machines is preparation for important defense jobs





Nursing attendants can increase our nurse power by supplementing professional personnel

The floor plan has been blue-printed, showing allocation of consultation, operating, laboratory, sterilizing, and storage rooms, lavatories, and also men's, women's, and children's wards. Provision has been made to transform the three rooms now used for health examinations and training of the medical secretaries into a maternity wing. Babies have such a way of interrupting the best of plans, especially in disaster!

Posted at the door of each room is a plan showing the placement and spacing of cots, together with a list of equipment and personnel required for that particular unit. Emergency duties have been listed and assigned to each member of the staff. Stations have been assigned to qualified students, and instructions given so that they know where and to whom to report for duty.

Copies of this plan, complete with blue-prints, charts, and lists, have been submitted to the school board and sent to the regional and local offices of civilian defense.

#### CLASSES ADJUST TO WAR NEEDS

##### *Nursing attendants class*

The nursing attendants with their two-year training in the school—including six weeks in a hospital—are particularly well prepared to alleviate the burden of the registered nurse by giving simple nursing care which does not require professional skill and yet is so necessary to the comfort of the patient. The need for this auxiliary nursing service in the present emergency is recognized. The U. S. Office of Civilian Defense has stated that there is a lack of adequate professional nursing service:

In the face of the need for rapid expansion of nursing services for civilian defense, the number of available nurses is being depleted because of the requirements of the military forces and the public health and industrial hygiene services.\*

The students in the nursing attendants

\*U. S. Office of Civilian Defense, Medical Division. *The Journal of the American Medical Association*, August 30, 1941, p. 795.

Nursing attendants learn to prepare meals in the kitchen of the school apartment, which is equipped with excellent practice facilities



class have made and sterilized surgical supplies which are kept in reserve for possible disasters or other emergency. The graduates of the course are all working as hospital aides and they are prepared to serve in this capacity in the school if it should be used as a defense hospital.

These students are selected on the basis of good health, manual dexterity, and interest in the work. They take entire care of the rooms which they use at the school and take responsibility for assisting the nurse as described previously.

#### *Medical secretarial class*

This one-year course trains high-school graduates to be secretaries to physicians. The curriculum includes medical dictation and transcription, office nursing, first aid, business procedures, and medical terminology. With this background the students are well prepared to help in an emergency—to

write detailed reports of cases requiring medical and surgical treatment, to administer first aid if necessary, and to give other kinds of assistance.

#### *Power machine class*

The power machine department is functioning both as a training center and as a production center in this hour of national need. This course is 1000 hours or one year in length. The students are trained to operate all types of machines, such as buttonhole, two-needle, and high speed machines so necessary in the production of army and navy supplies. As a production center the department in addition to its regular work has made over three thousand garments for the Red Cross including hospital gowns, pajamas, shirts, and layettes. It is constantly trying to increase its production and is equipped to make any kind of garment on short notice. These students make all the uniforms of various types used in the school.



*Trade dressmaking class*

This class has also been doing work for the Red Cross. Besides sewing on regular machines, the students in the two-year trade dressmaking course are working on power machines to prepare for jobs in factories producing uniforms, parachutes, and other military equipment. Should the school be used as an emergency hospital this group will be responsible for the linen-room—making, mending, and dispensing linen as needed.

*Commercial foods class*

The members of the commercial foods classes are trained in a two-year course to prepare and serve food in hospitals, restaurants, camps, hotels, and schools. They know how to operate and care for standard equipment and machines used in quantity cooking.

In this present emergency members of the class can help in their own communities. As volunteer workers they are ready to assist in canteens as food workers or counter girls. Should the

school be used as an emergency hospital this group would prepare and serve meals to patients and staff. Already they have prepared menus to be used in such an emergency.

*Beauty culture class*

Morale is a woman's business. The beauty culture department, which gives a year's course, considers itself the morale department. Ernest Bevin, British Minister of Labor, announced recently that hairdressing and permanent waving machines have been installed in war factories in England to keep war workers happy. Appearance is important—it keeps up morale.

*Adult classes*

Adult classes are given after the regular school hours for women of the county. These are unusually well attended. The women are earnest in their desire to learn and to prepare for service in their local communities. Among the courses offered are: first aid (junior, standard, and advanced), home

Future industrial workers receive training in the power machine class



nursing, nurse's aide, nutrition, canteen, consumer education, child care, clothing, and victory gardening. The nurse teaches the home nursing and nurse's aide courses and assists in teaching the first-aid classes. The spacious school grounds are particularly well adapted for the course in gardening.

The school garden is the special pride of the students. They all participate in caring for it as a part of their physical education work. The value of a garden in these times is well expressed in a committee report from the New Jersey Agricultural Experiment Station:\*

Any program for the development of gardens for victory must include the growing of trees, shrubs, and flowers, for the health of the mind,

\*From A Summary of the Victory Garden Conference Held in Washington, D.C., December 19-20, 1941, prepared by L. A. Bevan, L. G. Schermerhorn, B. C. Blackburn, and K. W. Ingwalson.

as well as vegetables for the health of the body. Ornamental gardening is a vital and essential part of American life today, and its value as a stimulus to national physical and spiritual well-being is beyond calculation. . . .

The school grounds are a source of enjoyment and many parties are held around the outdoor fireplace.

The school is also used by the county for group meetings. Recently a Victory Rally was held—with motion pictures, speeches by state defense officials, patriotic songs, and open house with refreshments served in the cafeteria. It was a neighborly party, so successful that plans are made to have some such affair once a month for the duration of the war.

What the vocational school has done and is planning to do is not unusual. It can be done by any school. But we like to think we are prepared to meet the emergencies as they arise—that we are part of a democracy, serving it in a democratic way.

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# Protamine Zinc Insulin

By ELLIOTT P. JOSLIN, M.D.

**The values of protamine zinc insulin in the control of diabetes, its limitations, and important points in its administration are discussed in this article**

**P**ROTAMINE ZINC insulin is the insulin of choice for the diabetic of today. Hagedorn's original protamine insulin, discovered in 1935, had a duration of twelve hours. That was considered a wonderful boon to diabetic patients, because it kept the disease under control for as long a period as was possible before with two doses of regular insulin. Hagedorn's discovery represented such an advance in treatment that it brought tears of joy to the eyes of parents of diabetic children and even to the severe diabetic—whose onset of disease may occur in any decade of life, although it is far more frequent in the earlier years. It was certainly wonderful to see how the jagged blood sugar curves which were obtained with regular insulin were flattened out with protamine insulin.

It seemed, therefore, almost too good to be true when in 1938 Scott of Toronto again doubled the action of insulin by his insertion into the protamine insulin mixture of a fraction of zinc. Indeed, the prolongation of action was not confined to twenty-four hours, because a remnant of it was found to persist for even forty-eight hours. To this our group can testify, because in tests which we have sought to make upon the efficacy of other insulins, we have always been obliged to omit protamine zinc insulin for two days or else the test of the insulin to be studied would be invalidated.

The prolongation of the action of insulin by the addition of protamine and again of zinc was followed by a striking

decrease in the development of diabetic coma. Indeed, the better results in the actual treatment of coma can be attributed in considerable measure to the fact that the patient has been on protamine zinc insulin. (Protamine zinc insulin is not the insulin with which to treat diabetic coma, because one needs under such circumstances a quick-acting insulin such as regular or crystalline insulin. For a quick-acting insulin we use exclusively crystalline insulin, which acts as rapidly as the regular insulin, with effect lasting for about an hour longer.)

## DECREASE IN COMA

The reason protamine zinc insulin has led to a reduction in the incidence of coma is as follows: Formerly, if a patient omitted a dose of insulin, his diabetes became uncontrolled within six or seven hours, and in a severe case, acidosis began to arrive; whereas now, if a single dose of insulin is omitted, the patient is protected for a longer period, and coma therefore comes on more slowly and is more easily detected. The treatment of coma, likewise, is aided because even if too little protamine zinc insulin has been taken, the probability remains that at least some is acting in the body, and therefore, the coma is less apt to be so severe. It is a fact that among some 3600 admissions to the hospital for diabetes during 1940 and 1941, the total number of cases of coma has been but 62 with three deaths. Of these deaths, one occurred in a patient with schizophrenia, another was in a patient with

a carbuncle and an unsuspected tumor of the pituitary, and the third occurred suddenly a week after recovery from coma and a complicating pneumonia, out of a clear sky. Indeed, of our last fifty-two cases of diabetic coma between August 1940 and March 12, 1942, there has been no death in a diabetic patient with the plasma  $\text{CO}_2$  twenty volumes percent or less.

Protamine zinc insulin acts so gradually that it can be given without fear during an office visit. Moreover, the patient can be taught then and there to take an injection the following morning before breakfast, and thereafter slowly to increase it up to the point at which the desired effect has been reached, namely, the passage of a sugar-free urine on rising in the morning.

#### CONTROLS MILD DIABETES

Perhaps fifty percent of the diabetics in the United States can be and are controlled with a single dose of protamine zinc insulin once a day. Their diabetes is so mild that, although the protamine zinc insulin has no brains and therefore does not act with especial force during or after a meal any more than between meals, its effect is strong enough to prevent the escape in the urine of sugar ingested at the meal.

But one must remember the lines from Mulholland's contract (Kipling) and not lay on protamine zinc insulin any more than it can bear. Consequently, it is advisable, first, to spread out the diet of a diabetic patient taking protamine zinc insulin over a long period so that there will be lower peaks of blood sugar as a result of the ingestion of food at the three meals, and second, to reduce the carbohydrate at meals by giving a portion as a light lunch upon retiring, and sometimes in the midforenoon and afternoon.

For example, if the patient is allowed 150 grams of carbohydrate—and that is the minimum we want our patients to take—5 grams can be saved out of this

total allowance for a lunch at night before retiring. One or two soda crackers can be taken along with broth or a portion of the allowed milk at bedtime. Similarly, the fruit ration can be lessened at a meal to furnish between-meal carbohydrate.

If the patient is allowed more than 150 grams of carbohydrate, a larger amount of carbohydrate may be saved out of the total daily allowance and taken at midmeal lunches.

The heaviest allowance of between-meal carbohydrate would be that upon going to bed. Protamine zinc insulin, like the well known advertisement for a certain cathartic, "acts while you sleep," and therefore the blood sugar during the night when no food is taken might drop unduly low. To protect the patient in the early morning hours, therefore, the bedtime lunch is advantageous and it can be increased by the addition of a little cheese, peanut butter, or nuts. One of my patients, a priest who must say mass, is careful not only to choose the earliest mass in the morning of the five which are given in his church, but also to guard against low blood sugar and an insulin reaction by changing his habit of eating two soda crackers and half a glass of milk on retiring to eight biscuits on Saturday night.

#### SUPPLEMENT FOR SEVERE DIABETES

Although protamine zinc insulin protects the child and the severe diabetic and maintains a better control of the disease than would be possible without three or four doses of the quick-acting regular or crystalline insulin, yet it does not control the disease. It does not act strongly enough to offset the increase in blood sugar in these individuals, resulting from the food consumed at breakfast, dinner, and supper. Consequently, in another 25 percent of diabetics in the country I suspect that protamine zinc insulin is or should be supplemented before breakfast by the quick-acting

regular, or preferably, crystalline insulin, the effect of which continues for about seven hours. The remaining twenty-five percent of patients require no insulin at all.

Patients vary as to the relative quantities of the two insulins needed to control the disease. Some will take one part of crystalline insulin plus three parts of protamine; for example, 8 units of crystalline plus 24 units of protamine. Others will take 6 units of crystalline plus 36 units of protamine. The doses of the two are easy to decide upon.

Among 500 of the 1800 patients discharged from the George F. Baker Clinic of the New England Deaconess Hospital during 1941, the percent discharged with protamine zinc insulin alone was 56.8, average units 16.6; the percent discharged with crystalline insulin plus protamine zinc insulin, taken by separate injection before breakfast, was 26.4, average units 10.8 of crystalline plus 31.4 of protamine; the percent without insulin was 16.8. The average carbohydrate at discharge for the entire group was 158 grams. These figures are heretofore unpublished and constitute a partial compilation of data on patients discharged from the hospital in 1941.

The proper quantity of protamine zinc insulin is determined by the presence or absence of sugar in the urine on rising. There is one exception to this rule. Sometimes a patient may void before-breakfast urine containing sugar and yet the quantity of protamine zinc insulin may be adequate. This is because, although the urine manufactured in the kidneys in the late morning hours may be sugar free, the sugar found in the urine represents that manufactured soon after midnight or in the very early morning hours. Yet this fact is not recognized because the night urine is all mixed together in the bladder. For this reason, a second specimen test is desirable when the patient voids a morning urine containing sugar. If the bladder

is well evacuated, the second specimen should represent the true condition of the body at that time. If this second specimen shows a positive Benedict's test, the protamine zinc insulin should be increased; otherwise it should not be changed.

The dosage of crystalline insulin is regulated by the tests of the urine which are made during the forenoon and afternoon.

#### REACTIONS CAN BE AVOIDED

Insulin reactions due to protamine zinc insulin can be readily avoided if the patient will only bear in mind that protamine zinc insulin is continually acting day and night whether he eats or not. I have seen a patient whose diet was beautifully calculated and whose insulin dosages of crystalline and protamine zinc insulin were exemplary; yet she was in a pathetic state because of reactions. The only change in treatment was to suggest that she take a little food on retiring and that in the morning at the time the two insulins were injected, she eat her breakfast fruit. She has done so well that I have never seen her since, although yearly I receive evidence of her good condition.

Lack of food is not the only factor which lowers the blood sugar. It is also brought about by extra exercise, and consequently, the patient who wishes to avoid trouble—*i. e.*, a reaction—must remember to take a little extra food if he is going to indulge in unaccustomed exercise. For instance, one patient did perfectly well while driving home in his automobile each afternoon, but when the car broke down and he walked home uphill, he had symptoms of a reaction when he entered his house. In general, however, the rule is that any diabetic who drives an automobile invariably should take a little food every two hours.

Protamine zinc insulin and crystalline insulin are best given as separate injections before breakfast. Dr. Howard F.



Root, Dr. Priscilla White, and I are unanimous in this opinion. Although it is perhaps more convenient to give the two in one syringe, the procedure is too complicated especially for the very young or the very old patient. However, this is not the only reason for two separate injections. If crystalline insulin and protamine zinc insulin are mixed, the excess of protamine zinc insulin is sufficient to change over some of the quick-acting insulin into that of the longer acting, and one never knows exactly what the effect will be. There are too many variables in the treatment of diabetes anyway—such as those due to mistakes in diet and those due to variation in exercise—to add another variable in the dosage of the medicine.

The virtue of protamine zinc insulin resides in the solid and not in the liquid portion of the contents of the vial. Consequently, one must secure an even distribution of the solid particles or else one might obtain too much or too little of the actual insulin. Shaking the bottle should not be violent or else one obtains foam, and of course there is practically no insulin in that.

Protamine zinc insulin keeps for a somewhat shorter time than regular or crystalline insulin and I believe the date specified for usage is one year instead of the two years for the other types. (However, I would welcome unused bottles of protamine zinc insulin of more than a year's duration, because I suspect the deterioration would seldom be ten percent and my patients would be only too happy to get for nothing insulin of

which they must inject 44 units to derive the benefit of 40 units.) Incidentally, it is a good plan these days for patients to keep two bottles of unused insulin in the ice chest in order to guard against unforeseen eventualities.

#### SYMPTOMS OF REACTIONS

Reactions from protamine zinc insulin come on slowly and are most apt to occur in the early morning hours before rising, while dressing, or any time several hours after meals if unaccustomed exercise is taken. The reactions are not ushered in by hunger, tremor, and sweating as with regular and crystalline insulin; but more often by nausea, sometimes vomiting, headache, and an indisposed, out-of-sorts feeling. A patient may be accused of a bad temper when his behavior is simply due to a low blood sugar. However, this occurs also with the other types of insulin. If the reaction is not promptly relieved, sometimes it may progress to unconsciousness and even convulsions. In any unconscious diabetic patient, relief should be obtained within fifteen minutes or else the patient should be transferred to a hospital unless all the facilities of diagnosis and treatment are available which one could secure in a hospital.

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AUTHOR'S NOTE: If any reader has a question which he wishes to submit for a more detailed answer, I will be more than happy to reply. Moreover, any nurses wishing to attend our morning talks at 10:30 a.m. or afternoon classes at 1:15 p.m. at the George F. Baker Clinic of the New England Deaconess Hospital in Boston will be welcomed.

REMEMBER THE BIENNIAL CONVENTION TO BE HELD IN CHICAGO, ILLINOIS, MAY 18 TO 22. MAKE YOUR RESERVATIONS NOW.

# Tuberculosis Case Discussions Help Us

By ETHEL A. EVERINGHAM, R.N.

**Individually and as a group these public health nurses asked for help with their tuberculosis problems; the answer was found in monthly case conferences**

**G**ROUP THINKING and group action are recognized as effective methods of solving problems. Workers interested in tuberculosis control in Onondaga County, a rural area of 90,000 population in upstate New York, felt the need to sit down around a table together in order to discuss difficulties, report on progress, and share in the benefits of the broad knowledge and varied experience of the medical, nursing, social, and psychiatric groups.

The case discussion method was selected as one means through which health workers could more effectively meet the needs of the individual patient and the family in which tuberculosis is a problem.

There are twelve nurses engaged in generalized public health nursing in the county. Seven are employed by the county board of supervisors. Four have been assigned to the county by the State Department of Health—two as public health nurses and two as junior public health nurses in training. One nurse is employed by a town and village board of health. The county has a full-time public health nursing supervisor.

Every nurse recognized the extent of the problem confronting her, and realized that it called for concerted effort. Individually and as a group the nurses asked for help.

Fortunately, emphasis had been placed on tuberculosis in the statewide staff development program the previous year, when newer methods of control and treatment and a statement of the present

situation and problems were presented by specialists. These larger meetings were followed by smaller round-table discussions in which the new knowledge was applied to specific situations encountered by the nurse. Planned conferences for public health nurses were held at the tuberculosis hospital in the area, where methods of treatment, both medical and nursing, were demonstrated.

## THE PLAN OF THE CONFERENCES

The first case discussion was held in February 1941 following this preliminary groundwork. Monthly conferences have been conducted since that date. One week previous to the conference date, the nurses wishing to discuss families each submit a summary on a form developed by one of the group. Included are the following data:

- Name and address of patient
- Diagnosis and date
- Date of last examination
- Date and result of sputum examination
- Names and ages of contacts
- Dates of examination of contacts
- Names of contacts not examined and reasons
- Remarks

These summaries are sent to the district health officer so that he may review the information available on the tuberculosis case register. The data are also sent to the medical superintendent and supervising nurse at the tuberculosis hospital so that the x-rays and history may be reviewed in advance of the conference.

The district supervising public health nurse serves as group leader. The

physical setup is her responsibility—including an informal seating arrangement which will permit a view of the blackboard, the x-ray illuminator, and the group leader; proper lighting; and comfortable room temperature and ventilation. The meetings are held from 3:00 to 5:00 p.m.

Participating in the conference are the superintendent of the sanatorium, the district state health officer, the district state supervising nurse, the county supervising nurse, the sanatorium supervising nurse, all of the public health staff nurses working in the rural area, and any other workers who are especially concerned with the welfare of the patient or family.

The public health nurse first presents the family situation, using the nursing record as a source of information. The health assets and handicaps of various members of the family, the problem of tuberculosis as it affects them all, and the economic situation are presented by the nurse. Particular difficulties in adjustment which the families face or are unable to face are discussed.

#### **EACH WORKER MAKES CONTRIBUTION**

The patient's rejection of his diagnosis, the family's rejection of the patient, and emotional and economic insecurity are some of the problems that arise. The sanatorium supervising nurse is often able to make helpful suggestions. The clinician, by reviewing x-ray and other physical findings as well as the patient's history, offers suggestions which will be in the best interest of the patient and also contributes specifically to the education of the nurses present. The health officer's advice is given with consideration for both the welfare of the individual and the health protection of the whole community. Other workers, such as social workers from the family case-work agency, are invited to conferences concerning their clients.

Thus, the suggested plan is based on

the interests of the patient as an individual and as a member of the family group and community, with consideration for all the hopes and fears and loyalties that human beings have when confronted by problems of health and disease.

Although the thinking of everyone present is important in suggesting a plan for the family, the public health nurse is often the person who pyramids all the factors involved, by her knowledge in regard to adjustments in the home, the family's ability and willingness to follow precautionary measures, and the stage reached in the family's understanding of the disease and its care.

#### **GROUP THINKING HELPS**

We needed group thinking in regard to methods of helping patients and their families who present problems—such as failure of the patient to return for physical examination and x-ray, or unwillingness of contacts to have an examination. Failure to come for examination even after repeated home visits by the public health nurse shows the need for better teaching on her part or stimulation from some other source. How to bring this about was another subject for discussion.

The public health nurse often has difficult problems where she feels that she cannot accomplish the desired results without the physician's help. In some instances, the district state health officer has visited the home with the nurse to help explain to the family the importance of examinations or sanatorium care. This has proved most successful. Again, in cases where the private physician had previously assumed responsibility for the patient and the contacts had not been examined, a conference of the sanatorium superintendent or the district state health officer with the physician secured the desired results.

In some instances the welfare worker has been informed about the family's

increased needs for food and supplies to care for a sick patient in the home. Welfare workers are often unaware of such conditions. When informed by a reliable source their coöperation is usually excellent.

#### PROBLEMS ARE INDIVIDUAL

No immediate economic problem was involved in the case of Gerald, a young adult who was boarding in a home where there were several members in the age group having a high incidence of tuberculosis. The problem concerned his presence in this family group. The clinician and the health officer conferred with the family physician with the result that the patient willingly accepted hospitalization and all contacts were examined.

Mary, another young adult, had been diagnosed as having minimal pulmonary tuberculosis, but had not been examined since her initial examination. She had no family physician. She was extremely fearful and refused to discuss tuberculosis with the public health nurse, supervising nurse, or social worker. As a result of the case discussion, the health officer visited the home with the nurse. The first part of the visit was carried on with Mary out of sight but apparently within hearing. The modern approach to tuberculosis was stressed. The result—which took longer to accomplish than to relate—was that Mary and her family gained an understanding of her condition, were examined, and became advocates of methods of prevention and control.

Of course, all problems are not so easily solved. Examples might be given of the young man employed as a food handler who moved from one county to another, the selective service rejectee who temporarily disappeared from home, the father who wished to remain at home with fifteen household contacts. Tuberculosis control, especially in rural areas, still presents many problems which

we are sometimes apt to refer to in the past tense. Many of the difficulties in adjustment regarding attitudes toward the disease and its treatment are still found. For this reason the group has felt a need for psychiatric guidance which has not as yet been worked out.

The conferences offer an opportunity for the group to become more familiar with the various resources available through other organizations.

The need for rehabilitation of former tuberculosis patients is another problem discussed, and practical suggestions are often brought out through group discussions. For example, a former sanatorium patient 27 years of age had sufficiently recovered to return to work but was not yet ready for foundry labor in which he had been formerly employed for eleven years. During a conference discussion the sanatorium superintendent suggested employers who might provide the type of work the patient could perform. He was given these names and soon secured a satisfactory job.

Careful notes of each meeting are taken and a mimeographed copy is sent to every member of the group for future reference in regard to the cases discussed and suggestions made. At each meeting, the cases previously presented are briefly reviewed and the nurse or physician reports on what has been accomplished. From six to eight new patients and their families are presented each month for discussion.

The result of the conferences is a more intelligent approach to problems; better, more comprehensive care for the individual and his family; more economical and effective planning for the community; a better understanding of the service of all workers concerned; and an acceptance of the fact that tuberculosis control cannot be successfully accomplished by any one group of workers or any one agency but is a large endeavor calling for an all-out effort by every individual in the community.

# The School Nurse and Civilian Defense

By MARIE SWANSON, R.N.

Suggestions are made to the public health nurse in the schools for analyzing her job and making adjustments to meet the new needs of the wartime emergency

SCHOOL NURSES all over the country are asking what part they should play in civilian defense. This question is answered for them, as for others, in Marian G. Randall's article, "*Your Part in Civilian Defense*."\* However, an interpretation in relation to the particular activities of the public health nurse in the school may be helpful to her.

The school nurse shares the responsibility of her district and state nurses' association to make the national survey of registered nurses as complete as possible. There are still opportunities for her to discover nurses who have not returned their questionnaires or even nurses who did not receive them. She goes into homes which others do not reach, under circumstances that make it easy for her to discover whether there is anyone in the family who is a graduate nurse.

She perhaps more than any other nurse shares with the local league of nursing education responsibility for recruiting a sufficient number of the very best type of candidates for schools of nursing, for she is in a position where she will be asked for advice both by students and vocational counselors. Therefore she should have—or make available to the vocational guidance director in her school—complete information regarding entrance requirements and costs for

schools of nursing in the area, and should assist prospective students in making their applications and plans. When it is impossible for desirable applicants to secure necessary funds for this education, the nurse is often successful in finding an individual or a group to sponsor the students through loans or scholarships. She is usually better acquainted with the senior class than any other nurse, and can help the guidance personnel to direct promising young women toward the university schools of nursing or other good nursing schools. She can secure from the Nursing Information Bureau, 1790 Broadway, New York City, pamphlets for use of students in selecting a school of nursing.

The public health nurse working in the schools is frequently well equipped to assist in teaching first-aid and home-nursing classes. Since others besides nurses can qualify as first-aid instructors, she often concentrates on the home-nursing classes. She may give valuable service in organization of classes, in securing rooms and equipment, in finding nurses to do the teaching, and in helping less well prepared nurses with their teaching. Nurses who are less experienced as classroom instructors may appreciate the opportunity to observe or assist in the school nurse's classes.

If the Red Cross course for Volunteer Nurse's Aides is offered in the community, the school nurse may be helpful in finding and interesting just the right women and girls for this important

\*Randall, Marian G. "*Your Part in Civilian Defense*." PUBLIC HEALTH NURSING, January 1942.



group. Through her broad contacts with all economic groups represented in the school, she sometimes has a wider acquaintance than other public health nurses with those young women who are in the economic group having some leisure time, and who have not previously engaged in community activities.

School nurses are responding generously to the call for service. Problems have been encountered in deciding which calls to answer and which to refuse—since obviously some must be refused. Perhaps due to the conspicuous position and easy accessibility of the school nurse in the community, she is sometimes called upon for more service than it is wise for her to give. Like other public health nurses, she will have to consider carefully what contribution she is best equipped to make.

The experience in England has shown that the nurse's services in the schools must be expanded, not contracted, under modern civilian war conditions. Even in undisturbed areas, schools find an increase in problems to be handled, due directly to war conditions. Health problems—particularly emotional and social—are growing out of family disruption due to the departure of adults for military service and especially to the increased employment of mothers. Continuity and stability of the child's social group in schools help reassure him under these conditions.

#### ASSIGNMENT TO EMERGENCY SERVICE

The care of evacuated children in England is described by Dr. Martha M. Eliot, who was sent to England to study the handling of this problem: "At first the problems [in the evacuation of city children] were many because the city schools were closed and school doctors and nurses and health visitors were called to duty in the Emergency Medical Services. That this was a mistake was quickly recognized. The need to assign workers of these types to the reception

areas and continue their services in the evacuating areas was soon obvious. Doctors, nurses, and health visitors were recalled to duty in the school and child welfare services."\*

It is evident in this country, as in England, that the school nurse should not accept an assignment to a casualty station or first-aid post during school hours. It is also questionable whether she should accept one for out-of-school time because she may be needed to help with emergencies in connection with the school itself. We still find it very difficult to visualize this "emergency" for which we are planning. The very emergency that will require nurses in casualty stations may at the same moment affect the school group or may have already caused their removal as a group from school or from the community.

Although the nurse in the school is working in one of the most important phases of civilian defense, this does not mean that she should continue to engage undisturbed in the activities—however excellent—which required all of her time before this emergency.

#### MUST ANALYZE HER JOB

While the vital health service duties of the nurse must not be sacrificed to other demands, it is possible and necessary to rearrange programs, change emphases, and utilize auxiliary assistance so that essential needs can be met and additional or enriched services may be possible to meet new problems. Some nonvital routines may be omitted. Supervision by the nurse may replace performance by the nurse in some activities. Her time may be conserved by more efficient telephone or messenger service; by adequate secretarial service for correspondence to replace some personal contacts, and for work on records and reports; and by greater use of volunteers.

\*Eliot, Martha M. "The Protection of Children in a National Defense Program." *Medical Women's Journal*, August 1941, page 246.

"Let the teacher do it" is no solution. Allocation of duties to the nurse or teacher should be made now, as at all times, on the basis of who can do them most effectively from the standpoint of meeting the child's needs. There is a shortage of teachers as well as nurses, and many additional responsibilities are being assigned to teachers. A careful scrutiny of the whole program of health activities may show some things previously assigned to the nurse which could be done better by the teacher, but it may show also some which should be transferred from the teacher or the physician to the nurse.

Of the activities ordinarily carried on by the nurse in the school, there are some involving a minimum of nursing skill and judgment which can be assigned to volunteer or clerical service without requiring an impractical amount of training or supervision by the nurse. Others requiring a greater degree of skill but a minimum of nursing judgment can be assigned to a carefully selected, permanently employed worker of the clerical, technician, or secretarial type, provided the amount of time required to train and supervise this individual does not prove to be greater than the time saved by her services.

Some examples will be given here of an analysis of the nurse's activities in the schools with the purpose of suggesting an allocation of duties to non-nurse workers. Possible assignment of the activities is indicated as follows: V for volunteer, C for clerical worker, N for school nurse, T for teacher, and D for doctor. (It is understood that the superintendent, principal, teacher, and physician are involved in practically all of these.)

Activities involved in the periodic physical examination include the following:

1. Checking health records with register

V C

2. Making out headings for new records V C
3. Obtaining health histories by questionnaires to parents C T
4. Obtaining health histories by interviews with parents N T
5. Scheduling health examinations C N T
6. Preparing examination room V C
7. Psychological preparation of pupils for examination N T
8. Physical preparation of pupils for examination V C
9. Weighing and measuring pupils in connection with periodic physical examination N T
10. Recording weights and heights on health records V C
11. Recording weights and heights to send parents V C
12. Scheduling vision tests C N
13. Measuring visual acuity with Snellen test C N T
14. Making ocular muscle tests N T
15. Making color perception tests N T
16. Scheduling group audiometer tests C N
17. Giving group audiometer tests C N
18. Marking papers for audiometer tests V C
19. Recording results of audiometer tests on health records V C
20. Scheduling pitch range audiometer tests C N
21. Making and recording pitch range audiometer tests C N
22. Scheduling special health examinations for athletes C N
23. Scheduling special health examinations for working papers C N
24. Preparing health histories for working papers N
25. Scheduling preschool examinations C N
26. Listing prospects for preschool examinations V C N
27. Making contact with prospects for preschool examinations V C N
28. Being present at examinations N T

While it might appear that a volunteer could schedule examinations (see 5, 12, 16, 20), an intimate knowledge of the school system is required for efficient scheduling, which makes this undesirable as a volunteer activity in most instances. The educational possibilities of weighing and measuring in connection with the periodic physical examination make

these procedures so important that the teacher or nurse should do them if possible. If, however, they are done only for purposes of making a record, a volunteer can do them just as well. The psychological factors involved in doing the ocular muscle and color perception tests make those procedures the responsibility of the nurse and teacher. The presence of the teacher and nurse at the examination is important beyond their function of assisting the physician or chaperoning at the examination; they each have much to give to the examination and to get from it.

Activities involved in the follow-up to secure treatment of the defects and changes in the undesirable habits discovered in the examination or through the observation of the school personnel include the following:

1. Writing notices to parents regarding the defects found C N T
2. Addressing envelopes for the notices V C (pupils)
3. Collecting, recording, and filing these notices after they are returned signed C T
4. Informing teachers by interview of defects found N D
5. Preparing lists of defects found for teachers C N
6. Interviewing pupils in school regarding treatments N T D
7. Interviewing parents in school regarding treatments N T D
8. Interviewing parents at home regarding treatments N T
9. Verifying treatments reported by pupil and family N D
10. Recording treatments reported by pupil and family C N T
11. Conferring with cooperating agencies to secure treatment N D
12. Assisting with utilization of clinic facilities—informing parents N T
13. Assisting with utilization of clinic facilities—making appointments C
14. Interpreting to the community the need for additional facilities N D

Activities involved in the continuous

health supervision of pupils and environment include the following:

1. Making sanitary surveys of the school plant V C N T
2. Making daily informal classroom inspections T
3. Making daily classroom inspections during an epidemic N D
4. Taking care of pupils referred from classroom inspection N D
5. Supervising ill or isolated pupils at school V C N
6. Taking ill pupils home N (parents)
7. Interviewing pupils returning after an illness N D
8. Keeping up-to-date lists of pupils out of school ill V C N
9. Giving first-aid treatment N T D
10. Reporting first-aid treatment C N T
11. Making follow-up of pupils after first-aid treatment N D
12. Supervising first-aid supplies V C
13. Reporting to and receiving reports from the health officer V C N

Responsibility for sanitary surveys should not be placed upon a volunteer, but there are many details upon which a volunteer may check. An ill child is not taken home unless it has proved impossible to have the parent send for him. If taking the pupil home is merely a matter of transportation, the nurse should not be used. However, this activity gives the nurse one of her best opportunities to do effective health teaching in the home at the moment when there is a manifest problem. Her visit gives the parent a feeling of confidence in the school and in the health service.

#### WARTIME NUTRITION OF CHILDREN

Increased emphasis on nutrition is a feature of the defense program which should function in and through the school. It may include (1) increased and vitalized instruction on nutrition (2) organization and teaching of classes for adults (3) installation or further development of a school feeding program. Members of the school personnel

other than the nurse have a first responsibility for the first two activities. But unless there is a full-time physician in the school, there is probably no one with a more vital concern in the school feeding program than the nurse.

The first question that arises in developing a school feeding program is: What is the present nutritional condition of the pupils? Nutritional surveys have shown that poor nutrition is found in children from all economic levels, but that the highest amount of malnutrition is found in the lower economic groups.

A recent statement by Dr. E. H. Wilkins on the problem of nutrition in England is applicable here:\*

The implication that the classifying of 90 percent of children . . . [as 'excellent' and 'normal'] indicates that the children are well fed is sheer nonsense, conflicting as it does with a mass of evidence based on ascertained fact.

However we may define nutrition, it is certain that the vast majority of children are round about the normal, but it is equally certain that few if any of the normals are in the state of maximum nutrition which alone is the state of health. The achievement of this maximum does not lie within the province of medical attention, but in obtaining the best environment conditions, especially during the period of development.

Until some more objective tests and measurements of nutritional conditions are available for use in the school examinations, the physician's evaluation of nutritional status based on clinical signs must be supplemented by observation of symptoms and behavior, by history, and perhaps most important of all, by information regarding the diet.

Observations will include data on growth and development, weight in relation to body build, muscle tone, posture, color, and condition of hair and skin, and mouth and teeth. Behavior indications of possible malnutrition include

lassitude, early fatigue, twitching, irritability, and fitful, interrupted sleep. A continuous year-to-year record of causes of illness and absence is often especially significant.\*

Information regarding the lack of sufficient food, use of the wrong foods, or poor eating habits—especially the omission of breakfast or lunch—is well worth gathering, recording, summarizing, and doing something about.

The splendid, simplified, authentic material on nutrition now available to the nurse for her teaching in her home calls will probably result in an increase in both the effectiveness and amount of such teaching. It will also help her in pointing her questions regarding home dietary practices so as to obtain the most significant information.

The public health nurse's participation in the school feeding program has included in some instances the following activities:

- Selecting pupils for free feeding
- Securing their coöperation
- Securing the coöperation of their parents
- Helping plan space, schedule, equipment, service, and supplies
- Making contacts with agencies and individuals to secure money for the program
- Transporting surplus commodities
- Helping to prepare and serve the lunch
- Recording—improvements in the children; expenditures; inventories
- Reporting—making financial and case reports
- Preparing material for publicity

The service of volunteers may be utilized in many of these tasks and the nurse may assist in training and supervising them in certain activities. In most school systems there is someone better qualified than the nurse to plan the meals, to supervise the volunteers in the preparation and serving of them, and to record and report on expenditures. But if there is no one else qualified to undertake these responsibilities, they

\*Wilkins, E. H. "Future of the School Medical Service." *The Lancet*, November 8, 1941, p. 577.

\*See "Malnourished Children in the School," by George M. Wheatley. *PUBLIC HEALTH NURSING*, May 1941, p. 300.

comprise an important service in which the nurse may have to participate.

Anything which can be done to reduce undue fatigue of children is a contribution to improved nutrition. There is a disturbing amount of fatigue among so-called normal children, which is intensified at the present time by the general tension and by loss of sleep due to the failure to adjust to the change to daylight time. The fact that children adjust quite easily to changes in schedule when they go to a hospital or to camp indicates that adjustment is more a matter of environmental control than of some unchangeable factor in the child. The nurse can help parents and children to meet this problem.

#### COMMUNICABLE DISEASE PROBLEMS

War conditions may bring new diseases within our horizon. We may have to learn about tropical diseases or other communicable diseases which are new in this part of the world. Even deficiency diseases may appear in parts of our country where they have never been seen before. Physicians are already taking cognizance of these possibilities and nurses should also be alert and follow professional literature even more carefully than usual in order to keep informed on all phases of this subject.

#### PREPARING YOUTH FOR WAR SERVICE

Increased attention must be given to the health of older pupils. When public health nursing service in the schools is inadequate there is a tendency to neglect the older children in favor of the younger. In fact many public health authorities have urged this emphasis if some sacrifice must be made. Others have suggested the need for a re-evaluation of this practice. Certainly at this time, when youth are needed at an early age for war industries or military service, the need for greater attention to their health is obvious.

Psychologists are also emphasizing the sudden transition which youth must make emotionally. During the depression, with an increasingly older population in this country, the effort has been made to prolong childhood, to keep youth in school and out of industry, and to give it as little really important responsibility as possible. Now a sudden maturity and acceptance of responsibility are expected—for which youth has had no gradual preparation. The public health nurse in the school, together with all the school personnel, has a part to play in helping youth make this sudden and difficult transition.

Many states have laws which make it impossible—theoretically at least—for a child to secure working papers and leave school unless his remediable physical handicaps have been cared for. No state, however, has a provision that high-school diplomas must be withheld or that pupils cannot represent the school in athletics, music festivals, dramatics, and other activities if remediable defects are neglected. Individual schools have set up such a standard with excellent results. To make this requirement effective in protecting the health of pupils, it is necessary of course that adequate treatment facilities be made available by welfare agencies for pupils whose families cannot pay for medical care. Necessary also—and more difficult to secure—is unofficial assistance in the form of part-pay and loan-fund plans for the many pupils who come from families not eligible for nor desiring welfare service, but lacking the money to secure what is needed.

It is not the nurse's responsibility to raise funds for the health care of these young people though in some instances she has done so. Without the services of a nurse, it is difficult for a school to secure the information necessary to determine the number of such children and the approximate increase in facilities or funds required to meet the needs.



Civilian defense requires that these young people be put in proper physical condition. At the present time such work is considered a local responsibility rather than one to be assumed by the Federal Government. Such information will therefore be presented to local defense councils by the school authorities after the nurse has prepared it.

Finally, emphasis should be placed on the importance of close coördination of all community health services, including the school services. Community planning—always essential to economical and effective health work—is now imperative in the light of probable de-

creased personnel and increased needs. The work of the public health nurse in the schools should be a part of a community plan in which all nursing services are closely dovetailed together in order to give family health service. More than ever, if she is a nurse in a specialized service, she has a responsibility for seeing the health needs of the family of each child under her supervision; for working out carefully planned relationships so that those needs will be met promptly and effectively. Only by such participation in the whole community plan for public health nursing is she doing her part to meet this emergency.

## News from the S.O.P.H.N.'s

**T**HE CALIFORNIA State Organization for Public Health Nursing came of age on May 23, 1941, when it celebrated its twenty-first birthday.

Actually the organization goes back an additional ten years to 1910, when a group of six nurses formed the Los Angeles Nurses Club, "to be of mutual aid in the furtherance of our work, and in helping others to help ourselves." The six original members were employed by that same municipality which, upon petition of a group of interested lay women of the College Settlement, appointed the first visiting nurse in the United States to be paid from tax funds. In 1912, the club accepted the invitation to become a member of the newly organized National Organization for Public Health Nursing.

San Francisco public health nurses had also formed an organization in 1914 "to promote good feeling and better understanding among nurses and social service workers doing public health work or any kind of welfare work for the public good."

The northern and southern groups combined in 1920 to become the California State Organization for Public Health Nursing, and Agnes G. Talcott, then a member of the N.O.P.H.N. Board of Directors, became the first president of the statewide organization.

The S.O.P.H.N. had a membership of 715 on May 1, 1941, including 128 new members. Its potential membership is 1288. There are 19 units in the Organization, with memberships varying from 11 to 219. Several units include from four to nine counties; one unit covers 20,000 square miles of territory, and includes 17 nurses in the membership. The newest unit to organize is the fourth in a county of 4000 square miles.

Board meetings are held alternately in San Francisco and Los Angeles in order to equalize the travel distance, which averages a 1000-mile round trip for members. Minutes of board meetings are sent to each unit president and secretary in an effort to bring the units into closer relationship with the State

Organization and keep them informed of plans and progress of activities.

A Defense Committee has been appointed with representatives from various sections of the state, to cooperate with the State Committee on Red Cross Nursing Service. The chairman represents the S.O.P.H.N. on the State Committee.

The Education Committee reports progress on the part of three joint district committees working with the California League of Nursing Education on plans for the integration of health and social aspects of nursing in the basic curriculum.

In former years the State Organization financed institutes for members and brought leaders from various sections of the country to the coast. Today, the units sponsor and make the local plans for institutes and educational conferences arranged by the Public Health Nursing Service of the State Department of Public Health. Usually luncheons are arranged in connection with the institutes to provide an opportunity for becoming acquainted with members from other sections of the state and for an exchange of ideas.

Members of the Organization act as members of advisory committees to local civil service commissioners to interpret recommended qualifications for public health nurses and assist in raising nursing standards in their communities.

The chairman of the Publicity Committee acts as editor of the public health section which since 1935 has appeared monthly in the *Pacific Coast Journal of Nursing*. Since 1937 the Committee has been responsible for one annual issue of the magazine, sponsored by the State Organization, which has developed into an inventory of public health nursing progress in California and the western states, with many distinguished contributors from state and national agencies. The theme for the August 1941

issue was "Mobilization for Home Defense."

In 1941 this Committee sponsored preparation by each unit of a history of public health nursing development within its area.

A manual for the guidance of the unit secretary was prepared by a special committee in 1940 to expedite uniform conduct of Organization affairs. Another committee revised the bylaws to conform with the N.O.P.H.N. constitution and bylaws.

The president is a member of the Committee on Legislation of the California State Nurses' Association and in 1939 the organization cooperated in the statewide legislative campaign to secure passage of a new Nurse Practice Act. Following the Governor's signature of the Act, a list of candidates from which an S.O.P.H.N. representative was to be appointed on the State Board of Nurse Examiners, was submitted to the Governor by the Board of Directors.

#### LAY MEMBERSHIP

Although public health nursing in California was started by interested lay women, the growth of lay membership in the organization has been slow. This may be due to the fact the majority of the nurses are employed by official agencies which have not so far emphasized lay participation.

The present lay membership chairman is actively interested in lay participation and has outlined a number of activities which have been submitted to the individual units for selection of projects suitable to their communities. Included are:

1. A survey of public health nursing resources in the local community.
2. A study of programs of local health departments, visiting nurse associations, and Red Cross services—including a day spent with a public health nurse on her regular activities in the field.

(Continued on page 226)

# Summer Courses for Public Health Nurses

SUMMER COURSES IN UNIVERSITIES WHOSE PROGRAMS OF STUDY IN PUBLIC HEALTH NURSING HAVE BEEN APPROVED BY THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

For students meeting the admission requirements, this work may usually be counted toward a degree.

## California

**Berkeley. University of California.** June 29-August 7. The following three-weeks' institutes (June 29-July 17) will be conducted as part of the summer session: (1) Supervision and administration in public health nursing agencies will be offered to registered nurses working in public health nursing agencies. Guest instructor, Ruth Hubbard, director, Philadelphia Visiting Nurse Society. (2) Principles of supervision and administration as applied to schools of nursing will be offered to registered nurses working in hospitals or schools of nursing. Guest instructor, Katharine Densford, director, School of Nursing, University of Minnesota, Minneapolis. (3) Defense nutrition. These institutes will carry three units of university credit. Tuition for the three-weeks' period will be \$17.50. Other courses in economics, education, physiology, and psychology will be offered during the regular session. For further information write to Margaret Tracy, director, School of Nursing, or dean of the summer session.

**Los Angeles. University of California.** June 29-August 7. Courses in elementary bacteriology, general bacteriology, principles of education, the conditions of learning, growth and development of the child, adolescence, administration of the school health program, vocational guidance, secondary education, social foundations of education, character education, rural society and education, elements of nutrition, family relationships, nutrition and growth of the child, sound and hearing, general human physiology, American institutions, introductory psychology, educational psychology, group psychology, home nursing, public health and preventive medicine, principles of teaching in public health nursing, methods in teaching home nursing, principles and practice of public health nursing, and social institutions. Also institutes on family living in 1942 (June 29-July 17) and recent advances in nutrition (July 20-August 7).

For further information write to J. Harold Williams, dean of the Summer Session.

## District of Columbia

**Washington. Catholic University of America.** June 29-August 8. Courses in principles of public health nursing, nutrition, public health administration, special phases in public health nursing.

For further information write to Lucia Sweeton, director of Division of Public Health Nursing, School of Nursing Education.

## Illinois

**Chicago. The University of Chicago.** First term, June 23-August 1; second term, August 3-September 12. Special arrangements will be made so that administrators and teachers who must return to their positions before the end of the quarter may complete in full by August 28 the work of the courses for which they are registered in the Department of Nursing Education. Students may be admitted to the following courses at the beginning of either term: introduction to the study of nursing education, current trends in American nursing, teaching professional problems, ward management and teaching, special fields in public health nursing. Students may be admitted to the following courses at the beginning of the first term only (the courses extend throughout both terms): the curriculum in nursing education, supervision in schools of nursing, administration of hospital nursing services, teaching nursing arts, principles of public health nursing, supervision in public health nursing, organization and administration in public health nursing. The following courses will be given as half-courses: (1) in the first term—evaluation of nursing procedures, the construction and use of achievement tests in nursing; (2) in the second term—the teaching of health. A limited number of

students from nursing education will be admitted to the workshop in general education for members of college staffs, which will be held July 27-August 28. The problems receiving major emphasis in the workshop will be those relating to the evaluation of college courses and programs, to curriculum and course revisions, and to comprehensive examinations. For further information write to Nellie X. Hawkinson, Department of Nursing Education.

**Chicago. Loyola University.** Courses in principles of public health nursing, physiologic hygiene, introduction to mental hygiene, principles of sociology, ethics, organization and administration in public health nursing, problems in health education, principles of social case work, introduction to sanitation, school health problems, social and public health aspects of mental hygiene, public health journal club, field work in public health nursing, field work in social case work, parasitology, public health laboratory methods, advanced public health statistics.

For further information write to Dr. Earl Kleinschmidt, chairman, Department of Preventive Medicine, Public Health and Bacteriology, School of Medicine.

#### Indiana

**Bloomington. Indiana University.** May 11-August 22. Courses in principles of public health nursing, maternal and child care, sociology, psychology, health education, and other related courses.

For further information write to Mrs. Bessie F. Swan, assistant professor of nursing education, School of Education.

#### Massachusetts

**Boston. Simmons College.** June 29-August 7. Courses in psychology, methods of teaching, principles of public health nursing, school nursing, nutrition, and supervision. Tuition \$20 a course.

For further information write to director, School of Nursing, 300 The Fenway.

#### Michigan

**Ann Arbor. University of Michigan.** Because of the war the university schedule is arranged to permit the completion of three full semesters of work in one calendar year. The School of Public Health will have two eight-week sessions during the summer—the first, June 15-August 8, and the second, August 10-October 2. The School of Education will have a sixteen-week session, June 15-October 2, and an eight-week session, June 29-August 21. In addition to the usual courses in public health and in education, special courses will be offered in orthopedic nursing (June 15-July 3), and tuberculosis nursing (July 13-July 31).

For further information write to Ella E. McNeil, associate professor of public health nursing, School of Public Health.

**Detroit. Wayne University.** June 22-August 24. Courses in English, psychology, and sociology required for the Public Health Nursing Certificate.

For further information write to Anna L. Jenkins, Department of Nursing

#### Minnesota

**Minneapolis. University of Minnesota.** First session, June 17-July 24. Tuberculosis and its control, mental hygiene for public health nurses, principles of public health nursing, field practice in rural nursing, field practice in family health agency, health education problems, problems in public health nursing. Second session, July 27-August 28. Elements of preventive medicine and public health, health of the school child, field practice in school nursing, field practice in rural nursing, field practice with family health agency, school nursing, special methods and supervised teaching in health education, nutrition for public health nurses, environmental sanitation, public health administration, topics in public health.

For further information write to Ruth Freeman, director of course in public health nursing, Department of Preventive Medicine and Public Health.

#### Missouri

**St. Louis. St. Louis University.** June 1-June 30, course in industrial hygiene for nurses. Instructor, Antoinette B. Wajdyk. July 1-July 29, course in public health nursing in venereal disease control. Instructor, Hazel Shortal. Other courses in methods of teaching applied to nursing, the teaching of nursing arts, and supervision of nursing service are offered from July 1-July 29.

For further information write to A. Louise Kinney, director, Division of Public Health Nursing, or Sister Mary Geraldine, executive dean, School of Nursing.

#### New York

**Brooklyn. St. John's University, Teachers College.** July 6-August 8. Principles and problems in nursing education, materials and methods in home nursing, and observation and practice in home nursing. Also courses in psychology for teachers, English, sociology, philosophy, history, and science. A course in first aid will be offered in June.

For further information write to Philomena Supper, director, Nursing Education Department, 75 Lewis Avenue.

**Buffalo. University of Buffalo.** First session, June 29-August 7. Courses in principles of public health nursing (the special fields), teaching in public health nursing (including practice teaching), field experience in public health nursing, nutrition, mental hygiene, educational psychology, field of social work, general psychology, and the growth and development of young children. Second session, August 10-September 18. Course in foundations in nursing education; also general university offerings.

For further information write to School of Nursing, 25 Niagara Square.

**New York. Columbia University, Teachers College.** Intersession, May 23-July 3. June 13-July 3, courses in nursery school and kindergarten education and modern family relations. Enrollment is limited. For further information regarding these two courses write to Dr. Ernest G. Osborne. July 7-August 14, courses in public health nursing, school nursing, teaching in public health nursing, and supervision in public health nursing. July 27-August 14, course in public health administration. Session, August 17-September 11.

Three weeks of intensive study for teachers of Red Cross courses in home nursing is offered in cooperation with the American Red Cross, May 23-June 13. Registration is limited to 40 authorized Red Cross home nursing instructors each week. Courses will include lectures, discussions, demonstrations, observation of teaching, and directed study. Sessions will be held daily from 9 a.m. to 5 p.m. Students may register for one, two, or three weeks. Emphasis will be as follows: principles of teaching applied to home nursing, May 23-29; scientific content of teaching home nursing, June 1-6; organization and presentation of materials of instruction, June 8-13. Registration fee is \$2 a week if taken without credit; \$12.50 a week if credit is desired. One point of credit is given for satisfactory completion of each week's work. Registration will close May 10.

For further information write to the Division of Nursing Education.

**New York. New York University, Washington Square.** Intersession, June 8-July 3. Principles and methods of teaching in nursing education. Summer session, July 7-July 24. Organization of school nursing I, problems in nursing education, administration of public health, principles of public health nursing I, observation and practice in public health nursing, methods of ward management, teaching of home hygiene and child care, nutrition, biology, psychology, social case work, and principles and practices in first aid (standard first-aid certificate). Summer session, July 27-August 14. Organization of school nursing I, problems in nursing education, the clinic—a family service, principles of public health nursing II, observation and practice in public health nursing, methods of ward teaching, the teaching of home hygiene and child care, nutrition, biology, psychology, social case work, and principles and practices in teaching first aid (prerequisite: standard first-aid certificate). Lake Sebago, July 6-August 14. Courses in orthopedics.

For further information write to Helen C. Manzer, School of Education.

**Syracuse. Syracuse University.** July 6-August 14. Principles of public health nursing, case studies in public health nursing, methods of teaching in public health nursing, special fields in public health nursing, nursing in schools, preventable diseases. Also courses in nutrition, sociology, education, and psychology.

For further information write to Ellen L. Buell, director, Department of Public Health Nursing, College of Medicine.

#### Ohio

**Cleveland. Western Reserve University.** June 22-July 31. Courses in practical sociology, the public health nurse in the control of syphilis and gonorrhea, public welfare, rural communities, supervision in public health nursing. Summer session, August 5-September 11.



Courses of general interest which will be open to public health nurses registered and advised through the School of Nursing.

For further information write to dean, Frances Payne Bolton School of Nursing.

#### Oregon

**Portland. University of Oregon.** June 22-September 4. Basic curriculum and curriculum in public health nursing and supervision. Institute for institutional and public health nurses, nursing—maternity and newborn, July 6-18.

For further information write to Elnora E. Thomson, director, Department of Nursing Education, Medical School.

#### Pennsylvania

**Philadelphia. University of Pennsylvania.** June 22-August 1. Courses in school nursing, teaching in public health nursing, social case work principles applied to public health nursing. General academic courses in sociology and education.

For further information write to Katharine Tucker, director, Department of Nursing Education.

**Pittsburgh. Duquesne University.** June 29-August 7. Courses in principles of public health nursing; public health nursing in maternity, infancy, and preschool service; sociology, psychology, and related courses in education; field practice in public health nursing.

For further information write to Grace Frauens, director, Public Health Nursing.

#### Tennessee

**Nashville. George Peabody College for Teachers.** June 8-August 21. Professional preparation of the graduate nurse for general community health service as well as some of the special areas, such as school and industrial nursing. Directed field work in rural and urban centers and in the Peabody demonstration and nursery schools. Public health work shop and other courses for advanced and graduate students.

For further information write to Division of Nursing Education.

**Nashville. Vanderbilt University.** June 8-August 21. Courses in principles of public health nursing, preventive medicine and public health administration, principles and practice of health teaching, and academic subjects leading to degree, B.S. in Nursing.

For further information write to dean, School of Nursing.

#### Washington

**Seattle. University of Washington.** First term, June 23-July 22; second term, July 23-August 21. Professional courses include special fields in public health nursing, social case work methods, methods of hospital supervision, principles of teaching health, and epidemiology. Methods of supervision in public health nursing will be offered to experienced public health nurses. Also courses in the allied fields of sociology, education, psychology, English composition, and public speaking. June 22-July 3. The university, with the coöperation of the U. S. Public Health Service, is offering a two-weeks' intensive course in public health nursing and venereal disease. Guest instructors: Donna Pearce and Dr. N. W. Guthrie, of the U. S. Public Health Service.

For further information write to Mrs. Elizabeth S. Soule, director, School of Nursing Education, University of Washington.

#### Wisconsin

**Madison. University of Wisconsin.** June 27-August 7. Principles of public health nursing IA and IB (3 university credits each); teaching in public health nursing (3 university credits); and field work (8 university credits).

For further information write to Mrs. Pearl Coulter, Department of Public Health Nursing, School of Nursing.

**Milwaukee. Marquette University.** First session, May 25-June 27. Various academic courses for graduate nurses. Second session, June 29-August 4. Academic courses and the following professional courses: principles of public health nursing (first and second course); maternal, child, and social hygiene; teaching home nursing and hygiene; advanced nutrition; principles and methods of teaching; field work in public health nursing; professional problems; ward administration; ward teaching; advanced course in teaching nursing; introduction to nursing education II; problems in nursing school administration; teaching the elementary nursing course; practice in ward administration and teaching; practice in a clinical specialty.

For further information write to dean, College of Nursing.

OTHER COURSES IN CURRICULA WHICH HAVE  
NOT BEEN EVALUATED BY THE N.O.P.H.N.

**California**

**San Francisco.** California State Department of Public Health and the San Francisco State Teachers' College. June 22-July 31. Three-unit course in social hygiene education. Two-unit lecture and one-unit workshop will be given by Dr. Helen Mackler of the Bureau of Venereal Diseases, State Department of Public Health.

For further information write to Ann W. Haynes, State Department of Public Health.

**COLORADO**

**Boulder.** University of Colorado. June 15-August 21 (registration June 12). Courses in principles of teaching nursing and health, administration of schools of nursing.

For further information regarding these and other courses write to Ruth Colestock, University of Colorado School of Nursing.

**ILLINOIS**

**Chicago.** Northwestern University. July 6-24. Courses in physical therapy in conjunction with the National Conference of the American Physiotherapy Association: physiology, applied anatomy, use of physical therapy in injury.

For further information write to the dean of the Northwestern University Medical School, 303 East Chicago Avenue.

**NEW JERSEY**

**South Orange.** Seton Hall College. June 29-July 17. Courses in nutrition and health, principles of public health nursing, dental health. July 20-August 7. Courses in child growth and development, school nursing, special fields in public health nursing. August 10-28. Courses in English, social studies, science, psychology, and education in this and the other two sessions.

For further information write to the School of Nursing Education, Seton Hall College, 72 Central Avenue, Newark.

**NEW YORK**

**Ithaca.** Cornell University. June 29-August 8. Courses in advanced first aid, bacteriology, nutrition, rural sociology, social problems, psychology, mental hygiene.

For further information write to L. C. Petry, director of the Summer Sessions, Cornell University.

**OHIO**

**Columbus.** Ohio State University. June 22-August 28. Courses in education for graduate registered nurses who are interested in working for a Bachelor of Nursing in Education degree.

For further information write to Raymond Bennett, secretary, College of Education, Arps Hall.

**PENNSYLVANIA**

**State College.** Pennsylvania State College. Intersession, June 8-26; main summer session, June 29-August 7; post-session, August 10-28. Courses include public school nursing, special problems of the school nurse in health service, advanced school nursing; also home economics, psychology, sociology, and related fields of especial interest and value to school nurses.

For special catalogue write to director of Summer Sessions, Room 105, Burrowes Building.

For information pertaining to certification requirements and special problems, address state adviser of school nurses, Department of Public Instruction, Harrisburg.

**Pittsburgh.** University of Pittsburgh. June 29-July 25. Courses in nursing procedures and routines, special studies in nursing and nursing education, community nursing, community health problems, school nursing; also courses in psychology, sociology, English, and the sciences.

For further information write to Mrs. Ruth Perkins Kuehn, dean, School of Nursing.

**TEXAS**

**Austin.** University of Texas. June 4-July 13. Courses in supervision in schools of nursing, teaching of nursing arts. July 14-August 24. Courses in community health, social hygiene.

For further information write to E. J. Mathews.

# A Clean Apron for Every Home Visit

By ELISABETH C. PHILLIPS, R.N.

**W**HEN the public health nurse opens her bag in the home of her first patient on Monday morning it is with pride and satisfaction that she takes out her spic-and-span apron and adjusts its ties. She knows, of course, that an apron fresh from the laundry gives the patient a feeling of safety and confidence, and that these two important foundation stones will help her to establish a valuable nurse-patient relationship.

But when, at the close of the day—or perhaps the second day—she takes out that same apron before giving care to her last patient, with what changed feelings does she put it on! Wouldn't we all be a little ashamed of its untidiness and somewhat perturbed by its history? There was the time it was worn while giving Mrs. Donovan an enema on the third day after her hemiplegia developed; then during the bath to Mr. Evans who had strained his back loading war materials at the quay-side; and at that demonstration to Mrs. Smiley of the best way to feed her protesting Patsy. Above all, there was that split second when the paper gown, and the apron beneath it, were drenched as the toothbrush and cup went flying when Johnny Wilson jumped up in bed to show off his new "chickens." Yes, the apron had a busy day long before it made its appearance in the home of Baby Dickens whose tired but proud mother-to-be was so eager to show off his newly acquired wardrobe.

Haven't we all yearned at such moments for a fresh apron? But reason quickly kills the wish, as we say to ourselves, "Laundering costs money and the cost per visit must not rise. Besides,

who ever saw a nurse's bag big enough to carry a supply of aprons sufficient to provide a fresh one for each patient, or a nurse's arm strong enough to carry that additional weight if the space were available? Absurd idea."

Something of this was in our minds when we were busy last winter assembling equipment for the public health nurses who were to be attached to the American Red Cross-Harvard Field Hospital Unit. There was the possibility, too, that laundering in wartime England might not be a simple procedure—nor is it—so it was with great relief that we learned of a new type of apron which might solve the problem.

This apron, in the style we are all familiar with, is made of a new material which has a soft, silky appearance, is very white, and although it is very pliable, does not muss easily. It is impervious to liquids but has no disagreeable rubber odor. The cost is about twice that of a good grade cotton apron purchased from the manufacturer—but there is no upkeep expense. It can be washed with soap and water after each patient, and the nurse can put it on at the close of the day with the same assurance of freshness and safety that she had at its beginning.

The technique as we have worked it out here in England is very simple. We discovered that the stock-size apron hung at least six to eight inches below the bottom hem of our uniforms, so off came the extra material, and with it bags were made to carry cleaning equipment for the apron. These bags are  $8\frac{1}{2}$  inches by  $4\frac{1}{2}$  inches in size, with a divided  $2\frac{1}{2}$ -inch flap, and are stitched down the center to make two pockets. Into one

we put a mitt of Turkish toweling—just a square made small enough so that when it is over the hand and the fingers are spread, it remains tightly in place, giving a good surface for friction. An ordinary small cloth hand towel goes into the other pocket. (Perhaps paper towels might be substituted where they are easily available.)

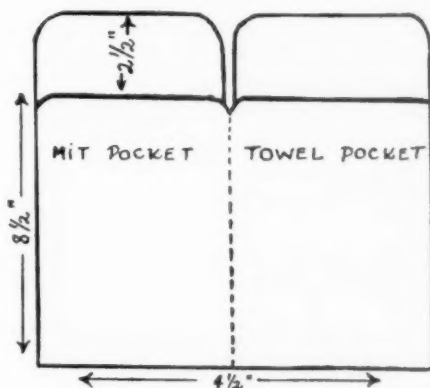
After the nursing care has been completed, but while the apron is still tied in place, the nurse puts fresh, warm water into a hand basin and washes her hands. She slips on the mitt, moistens it in the warm water, soaps it well with her hand soap, and systematically scrubs the entire surface of the apron. It can easily be pulled from side to side so that the back can be reached. The clean left hand rests upon the clean apron surface to steady it. The mitt is then rinsed, and the apron is wiped again in the same way. It is then dried easily and quickly with the towel. Afterward the mitt is washed and wrung as dry as possible before being slipped back into its bag. The hands are now clean and the apron is removed and folded away. The whole procedure takes about four minutes. Perhaps in a home where newspapers were plentiful, a clean surface could be provided and the apron washed lying flat on the table. It is doubtful, however, whether the time could be cut

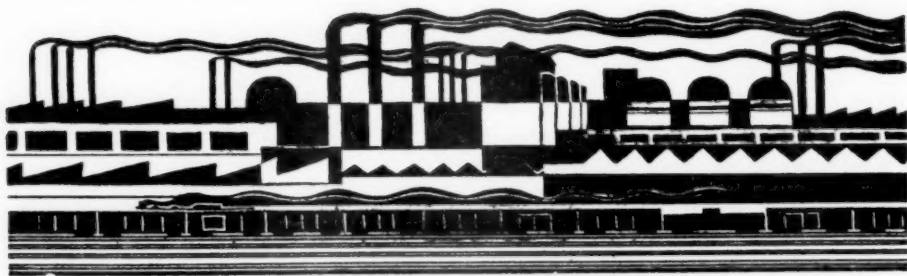
down or the efficiency improved. But in any case this is an impractical procedure here in a country where paper is too precious for us even to experiment with it. In rural areas in the United States the plan we use here might also be necessary.

Since this Field Unit is caring only for patients with communicable diseases, more than mere cleanliness is imperative. Does the soap and water cleansing really kill bacteria? We tested the procedure in the laboratory. A 24-hour culture of mixed staphylococci and *B. coli* was sprayed freely onto an apron. Several swab cultures were taken in order to prove the presence of the organisms and they were found to be present in large numbers. The apron was then washed as described above, three minutes being devoted to washing and one minute to rinsing and drying. It was then taken off and while the four corners were held together, 10 cc of sterile broth media were poured onto the inoculated surface. The broth completely covered the contaminated area. After mixing, 1/10 cc of this broth was cultured. No growth was found. As a control, one apron was autoclaved before being inoculated and the cleansing method was tested as before. The results were identical. Therefore, we conclude

(Continued on page 237)

Bag containing equipment  
for cleansing apron in  
the home after each use





## KEEP THEM WORKING

"KEEP THEM WORKING" was the keynote of a lively panel discussion meeting held by the Industrial Nurses' Organization of the Northwest District, Indiana State Nurses' Association, at Gary, Indiana, on January 20. Sixty persons attended the meeting. The nurse in industry and her relationship to management, personnel, safety, medical service, and industrial compensation laws were discussed.

The development of medical and nursing service in industry, with resultant decrease in industrial injuries and illness, was traced by the first speaker, the general superintendent of a large industry, who represented management on the program. "To the management of an industry," he said, "the worker is no longer just a member of the payroll, but a human being with family ties and responsibilities."

New personnel problems which will be raised by the depletion of the labor market in certain industries was discussed by the personnel director of a smaller industry with several similar plants. He said that the use of women workers to replace men and the use of men who are less physically fit will raise new problems which the nurse can help to meet.

The value of the industrial nurse in the safety program was emphasized by a safety director from a large defense industry. He outlined the functions of

the nurse in handling the injured employee with skill and tact, carrying out the physician's instructions in first-aid treatment and redressing injuries, and keeping accurate case records. He said the nurse's report on a worker's accident should answer three questions which give vital information to a safety inspector for preventing accidents: (1) Where was he working? (2) What was he doing? (3) What happened? He stressed the importance to accident prevention of checking personal safety equipment, such as safety shoes, gloves, goggles, aprons, wool clothing, and leggings. The nurse is asked to note, for example, whether an employee with a foot accident was wearing safety shoes; whether a worker with an eye accident was wearing goggles; and whether a victim of a hot metal accident was wearing wool clothing and leggings. These reports serve as the basis for a follow-up in the various departments to see that safety practices are being followed.

The value of the visiting nurse in industry was discussed by a physician from a large mill. He described her as the liaison person between the worker and the industry and said that she gives help to the employee with illness and other problems, and teaches the worker and family home hygiene and safety.

The nurse's responsibility in being able to distinguish between so-called minor complaints and injuries and poten-



tially serious ones was stressed by another speaker. He said that a repetition of the same kind of injury should be called to the attention of the safety supervisor so that the cause can be corrected. A repetition of the same complaint, such as colds, gastric disturbances, or joint pains, should be called to the physician's attention so that a thorough examination can be made. The nurse is often in a position to get a more authentic and complete story of the worker's injury or illness than is the physician.

The need for nurses to have a working

knowledge of industrial legislation was brought out by an official of a large industry, who stressed the fact that a minor injury or complaint may develop into something worse if not properly cared for.

The chairman of the meeting, a physician who is chairman of the Advisory Board of the organization, closed the meeting by emphasizing the responsibility of industrial nurses to enroll in the American Red Cross Nursing Service and to take their place in the wartime preparedness programs of their communities.

### FLUOROGRAPHIC UNITS TO BE LENT

Two 35mm. fluorographic units have been assigned by the States' Relations Division of the U. S. Public Health Service to the Division of Industrial Hygiene for loan to state industrial hygiene bureaus for the purpose of tuberculosis case-finding. The unit is composed of a stereo viewer, a screen, and an automatic camera. Each unit is accompanied by a medical officer who will in-

terpret the 35mm. films and a technician who will operate the camera. The salary and travel of these persons are paid by the Division of Industrial Hygiene. When assigned to a state, this personnel will be under the administrative direction of its industrial hygiene bureau.

—Summarized from *Industrial Hygiene*, Division of Industrial Hygiene, U. S. Public Health Service, December 1941.

### JOINT CONFERENCE PLANNED

AN INDUSTRIAL nursing conference will be held at the Benjamin Franklin Hotel in Philadelphia, Saturday, April 18, and the morning of April 19.

Participating in this fourth joint meeting will be the New England Industrial Nurses' Association, the New York Industrial Nurses' Club, the New Jersey Industrial Nurses' Association, the Philadelphia Industrial Nurses' Association, and the Detroit Industrial Nurses' Club. A luncheon will be held at 1 p.m., followed by a round-table session. Topics to be discussed are: Health Service in

Industry (New England), Why Do We Have Industrial Nurses? (New Jersey), Special Problems of the Industrial Nurse (New York), and The Industrial Nurse and National Defense (Detroit). Dr. Hubley R. Owen, director, Department of Public Health of Philadelphia, will be the speaker at a dinner to be held at 7:30 p.m.

Further information can be secured from Mrs. Marion C. Brittingham, president, Industrial Nurses' Association of Philadelphia and Vicinity, 6215 Erdrick Street, Philadelphia.

# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

## TENTATIVE BIENNIAL CONVENTION PROGRAM

CHICAGO, ILLINOIS, MAY 18-22

### JOINT SESSIONS

*Monday, May 18:* Opening Session, The Chicago Coliseum, 8:30 p.m.

Presiding: Julia C. Stimson, President, American Nurses' Association, and Chairman, Nursing Council on National Defense

Topic: Nursing at the Nation's Service

Invocation—Bishop Ernest Lynn Waldorf, Chicago, Ill.

Chorus: Augustana Hospital School of Nursing

Address of Welcome: Sarah Dailey, President of the Illinois State Nurses' Association

Response: Grace Ross, President, National Organization for Public Health Nursing

Address: The Health Needs of the Nation—Dr. Thomas Parran, Surgeon General, U. S. Public Health Service

Address: The Nursing Needs of the Nation—Marion G. Howell, Chairman, Subcommittee on Nursing

Address: Responding for All Nurses—Alta Dines, Director, Department of Educational Nursing, Community Service Society of New York

*Tuesday, May 19:* The Chicago Coliseum, 2:30 p.m.

Presiding: Grace Ross, President, National Organization for Public Health Nursing

Invocation—Rabbi Louis L. Mann, Chicago, Ill.

Report: The Nursing Council on National Defense—Julia C. Stimson, Chairman, Nursing Council on National Defense

Address: Public Health Problems in Defense Areas—Dr. Mark V. Ziegler, U. S. Public Health Service

*Tuesday, May 19:* The Chicago Coliseum, 8:30 p.m.

Meeting to be devoted entirely to the American Red Cross Nursing Service

*Thursday, May 21:* The Grand Ballroom, Stevens Hotel, 8:30 p.m.

Presiding: Stella Goostray, President, National League of Nursing Education

Invocation

Music: Songs—Mr. Bernie E. Comstock

Address: Maintaining Standards of Professional Education—George F. Zook, President, American Council on Education

Address: Education and the Defense of Democracy—T. V. Smith, Professor of Philosophy, The University of Chicago

### N.O.P.H.N. PROGRAM

*Saturday and Sunday:* Group Conferences\*

*Monday, May 18*

9:00-10:30 a.m. N.O.P.H.N. Board of Directors (closed meeting)

10:45-12:00 noon. N.O.P.H.N. General Session: Newer Treatment of War Injuries

12:30-2:00 p.m. Luncheon: N.O.P.H.N.

Sponsored by Industrial Nursing Section 2:30-4:00 p.m.

Round Table

Publicity—Speaker, William R. Slaughter, Medill School of Journalism, North-

western University, Chicago, Ill.

4:30-6:00 p.m.

Special Round Tables

Mothers' Milk Bureau—Leader, Eloise T. Phelps, Superintendent of Nurses, Health Department, Chicago, Ill.

Industrial Nursing—Leader, Joanna M. Johnson, Supervisor, Industrial Nursing Division, Employers Mutuals of Wisconsin, Milwaukee, Wis. Speakers—

Eleanor W. Mumford, Associate for Nursing Activities, National Society for the Prevention of Blindness, New York,

N.Y., Sight Conservation in Industry; Rispah Porter, First Aid Department,

\*See PUBLIC HEALTH NURSING, January 1942, page 53.

Chain Belt Company, Milwaukee, Wis.,  
Health and Safety of the Employee.  
Business meeting for Industrial Nursing  
Section

#### Tuesday, May 19

9:00-10:30 a.m. N.O.P.H.N. General Session: Adjusting to Wartime Needs.

10:45-12:00 noon. N.O.P.H.N. Business Meeting (open only to N.O.P.H.N. members, by membership card)

12:30-2:00 p.m. Luncheon: N.O.P.H.N. Membership Rally

2:30-4:00 p.m.

#### Special Round Tables

College Nursing—Leader, Raidie Poole, College Nurse, State Teachers College, Superior, Wis.

Round Table for Board and Committee Members—Speaker, Hilda Taba, Assistant Professor of Education, University of Chicago, Chicago, Ill.

Group Teaching—Leader, Eula B. Butzerin, Associate Professor of Public Health Nursing, Department of Nursing Education, University of Chicago, Chicago, Ill.

Supply and Distribution of Public Health Nursing Personnel—Leader, Pearl McIver, Chief Consultant, Public Health Nursing, United States Public Health Service, Washington, D.C.

#### Wednesday, May 20

9:00-10:30 a.m.

#### Round Tables

Maintaining Qualifications in Wartime—Leader, Elizabeth G. Fox, Director, Visiting Nurse Association, New Haven, Conn.

Supervision in School Nursing—Leader, Mary E. Chayer, Assistant Professor of Nursing Education, Teachers College, Columbia University, New York, N.Y.

Adjusting to Present-Day Problems—Directors and Lay Members in 1-2 nurse agencies; 3-9; 10-24; and 25 or more

10:45-12:00 noon

#### Round Table

Implications of Astoria School Health Study. Speakers—Dr. George M. Wheatley, Assistant Medical Director, Metropolitan Life Insurance Company, New York, N.Y.; Alice Miller, Director Health Education, Tuberculosis Institute of Chicago and Cook County, Chicago, Ill.; and Marion V. Fegley, Supervising Public Health Nurse, Department of Health, New York, N.Y.

Joint Session National League of Nursing Education and N.O.P.H.N. for Board and Committee Members' Section

12:30-2:00 p.m. Luncheon: N.O.P.H.N.

Sponsored by School Nursing Section

2:30 p.m. Sightseeing and Fashion Show

7:00 p.m. Dinner: N.O.P.H.N.

Sponsored by Board and Committee Members' Section

#### Thursday, May 21

9:00-11:30 a.m. N.O.P.H.N. General Session: Nutrition and Health

Speakers—Oris V. Wells, Chief Program Analyst, U. S. Department of Agriculture, Bureau of Agricultural Economics, Washington, D.C.; Marjorie Heseltine, Consultant in Nutrition, Children's Bureau, U. S. Department of Labor, Washington, D.C.; and Erna Proctor, Regional Home Economist, U. S. Department of Agriculture, FSA, Montgomery, Ala.

12:30-2:00 p.m. Luncheon: N.O.P.H.N.

Annual meeting for Board Members

2:30-4:00 p.m.

#### Special Round Tables

Fund Raising—Speaker, Clarence J. Myers, Executive Vice-President, Tamblin and Brown, New York, N.Y.

Maternity—Leader, Naomi Deutsch, Director, Public Health Nursing, Children's Bureau, U. S. Department of Labor, Washington, D.C.

Responsibility of Public Health Nursing Agencies in Relation to the Basic Curriculum—Leader, Mathilda Scheuer, Educational Director, Visiting Nurse Society, Philadelphia, Pa.

4:30-6:00 p.m.

#### Special Round Tables

Camp Nursing—Leader, Mrs. Helen Leighty, Director, Children's Welfare Federation of New York City, New York, N.Y.

Tuberculosis—Leader, Doris Kerwin, Milwaukee, Wis.

Administrative Plans for the Emergency—Leader, Katharine Faville, Director, Henry Street Visiting Nurse Service, New York, N.Y.

#### Friday, May 22

9:00-10:30 a.m. N.O.P.H.N. General Session: Public Medical Care

Speakers—Michael M. Davis, Chairman, Committee on Research in Medical Economics, New York, N.Y.; G. St. J. Perrott, Chief, Division of Public Health Methods, United States Public Health Service, Washington, D.C.

10:45-12:00 noon. N.O.P.H.N. Business Meeting (open only to N.O.P.H.N. members, by membership card)

A tea for the board members attending the Convention will be held Wednesday, May 20.

APPROXIMATE RAILROAD, BUS, AND AIRLINE FARES TO CHICAGO  
AND RETURN

City	By train <sup>1</sup>			By bus	By plane
	First-class fare (round trip)	Coach fare (round trip)	Lower berth (one way)	Bus fare <sup>2</sup> (round trip)	Airline fare <sup>3</sup> (round trip)
Albany, N.Y.	\$ 51.87	\$ 28.65	\$ 6.09	\$22.45	\$ 75.86
Atlanta, Ga.	38.75	26.72	6.14	19.45	63.90
Baltimore, Md.	48.72	26.57	6.09	22.15	
Birmingham, Ala.				17.50	
Boston, Mass.	63.89	35.44	7.46	28.00	
Charleston, W.Va.	32.81	18.48	4.15	14.95	
Concord, N.H.	68.46	38.90	7.46	28.00	
Denver, Colo.	53.81	43.10	8.03	33.15	92.64
Dover, Del.	53.55	29.45	6.14		
Fort Worth, Tex.	46.52	39.74	7.72	25.75	
Harrisburg, Pa.	45.78	24.78	5.51	20.45	61.10
Hartford, Conn.	57.70	32.08	6.62	26.05	
Memphis, Tenn.					48.38
Montgomery, Ala.	39.43	27.62	6.14	19.75	
Montpelier, Vt.	68.30	36.05	7.46	30.35	
Nashua, N.H.				29.35	
New Orleans, La.	48.88	34.55	7.46	24.40	83.94
New York, N.Y.	56.65	31.50	6.62	21.80	80.90
Oklahoma City, Okla.	41.69	33.39	7.19	21.70	
Providence, R.I.	63.74	35.44	7.46	28.00	
Richmond, Va.	53.55	29.40	6.62	24.30	
Salt Lake City, Utah	68.57	54.29	11.34	48.55	133.10
San Francisco, Calif.	104.32	75.08	17.38	66.35	189.00
Seattle, Wash.	104.32	75.08	17.38	66.35	
St. Louis, Mo.	15.17	12.44	2.78	7.95	23.30
Washington, D.C.	48.72	26.57	6.09	22.15	64.80
Wilmington, Del.				23.35	

<sup>1</sup>All railroad rates include 5 percent federal tax.

<sup>2</sup>All rates are for six months, with the exception of New York, N.Y., which is for two months.

<sup>3</sup>Add 5 percent tax to all prices.

#### FIELD SERVICE

MARCH has been a month of considerable field activity, particularly on the part of the orthopedic nursing staff. On March 19, Jessie L. Stevenson gave a talk on "Orthopedics in the School Program" at the school nurses' session of the Twenty-ninth Annual Meeting of Schoolmen's Week held at the University of Pennsylvania. Three institutes were conducted jointly, one by Miss Stevenson and Carmelita Calderwood and two by Miss Calderwood and Mary Macdonald of the Joint Orthopedic Nursing Advisory Service. The former was held on March 16 and 17 in Syracuse, N.Y., for a representative

group from schools of nursing and public health nursing agencies, and sponsored by the New York State League of Nursing Education; the latter were held in Durham and Gastonia, N.C., on March 23-24 and 26-27, respectively, and sponsored by the Crippled Children's Department, Division of Preventive Medicine of the State Board of Health, Raleigh. In addition, Miss Calderwood held conferences in Lincoln and Omaha, Nebr., with public health nurses, institutional nurses, and physicians, March 9-12.

On March 3, D. Irene Bigler spoke at the Greater New York Safety Convention and Exposition held at the Hotel Pennsylvania, New York City, on "The

Rôle of the Nurse in the Reduction of Physical Defects of Industrial Workers." On March 10, 17, and 24 Mrs. Bigler lectured on public health nursing in industry at Teachers College, Columbia University. On March 11 she gave a talk to the public health nursing students of Seton Hall College, Newark, N.J., on opportunities in industrial nursing and the work of the industrial nurse.

Ruth Houlton attended a meeting of state nursing council representatives called by the Nursing Council on National Defense and the Subcommittee on Nursing of the Office of Defense Health and Welfare Services, at the Stevens Hotel in Chicago on March 23 and 24.

Hortense Hilbert gave a talk on organization and administration of public health nursing to a group of students at the Harvard School of Public Health in Boston, on March 19.

On March 10, Ella L. Pensinger addressed a dinner meeting of the Visiting Nurse Association of Coatesville, Pa., on the occasion of its twenty-fifth anniversary. In late March and early April Miss Pensinger participated in a study of public health services in Columbus, Ohio, as the representative of the N.O.P.H.N.

#### HONOR ROLL

Most encouraging! Two hundred agencies are already on the 1942 Honor Roll. We are confident that many more have 100 percent enrollment, but have just not notified the N.O.P.H.N. If your agency does not appear on the list, won't you let us know as soon as possible so that you may receive your Honor Roll certificate, and the name of your agency may appear on the next published list?

The Honor Roll list is not cumulative during the year but each month we will publish the names of those agencies—whether they have one nurse or 100—who write us that all their nurses are enrolled in the N.O.P.H.N. for 1942.

#### ALABAMA

- \*Metropolitan Life Insurance Nursing Service, Anniston
- DeKalb County Health Department, Fort Payne
- Marshall County Health Department, Guntersville
- \*Elmore County Department of Public Health, Wetumpka

#### ARIZONA

- \*Miami Public Schools, Miami

#### ARKANSAS

- \*Metropolitan Life Insurance Nursing Service, Hot Springs
- Arkansas State Board of Health—Public Health Unit—Jonesboro

#### CALIFORNIA

- \*Metropolitan Life Insurance Nursing Service, Riverside

#### COLORADO

- Health Service Department of the Denver Public Schools, Denver
- \*Metropolitan Life Insurance Nursing Service, Denver
- \*Visiting Nurse Association, Denver
- Routt County Nursing Service, Steamboat Springs
- Logan County Public Health Nursing Service, Sterling

#### CONNECTICUT

- Bristol Visiting Nurse Association, Bristol
- \*Public Health Nursing Association, Darien
- Lime Rock Falls Village Public Health Nurse Association, Lime Rock Center
- \*Metropolitan Life Insurance Nursing Service of Danielson, Plainfield

#### DELAWARE

- Visiting Nurse Association of Wilmington

#### DISTRICT OF COLUMBIA

- Kiwanis Club Clinic for Crippled Children, Washington

#### FLORIDA

- \*Escambia County Health Department, Pensacola

#### IDAHO

- Lewiston State Normal School, Lewiston

#### ILLINOIS

- Metropolitan Life Insurance Nursing Service, Bloomington
- Macoupin County Tuberculosis and Sanatorium Board, Carlinville
- \*Ogle County Tuberculosis Sanatorium Board, Oregon
- \*Adams County Anti-Tuberculosis League and County School Nursing Program, Quincy

#### INDIANA

- \*Metropolitan Life Insurance Nursing Service, Gary

\*Agencies which have been on the Honor Roll for five years or more.



District Health Department No. 2—Indiana State Board of Health, Huntingburg  
 Marion County Board of Education, Indianapolis  
 Metropolitan Life Insurance Nursing Service, Logansport  
 \*Public Health Nursing Association, Terre Haute

**IOWA**

Davenport Public Schools, Davenport  
 \*Keokuk Public Schools, Keokuk  
 Metropolitan Life Insurance Nursing Service, Keokuk  
 District Health Service No. 3, Manchester  
 \*Metropolitan Life Insurance Nursing Service, Ottumwa  
 \*O'Brien County Nursing Service, Primghar  
 \*Black Hawk County Nursing Service, Waterloo

**KANSAS**

Wyandotte County Tuberculosis and Health Association, Kansas City  
 Kingman County Red Cross Nursing Service, Kingman  
 McPherson County School Nurse, McPherson  
 Public Health Nursing Association, Salina

**KENTUCKY**

Cumberland County Health Department, Burkesville  
 Adair County Health Department, Columbia  
 \*Metropolitan Life Insurance Nursing Service, Frankfort  
 \*Metropolitan Life Insurance Nursing Service, Henderson  
 \*Metropolitan Life Insurance Nursing Service, Owensboro  
 \*Visiting Nurse Association of Louisville, Louisville  
 Morgan County Health Department, West Liberty

**MAINE**

Bangor Anti-Tuberculosis Association, Bangor  
 Bangor Department of Education, Bangor  
 Lewiston Health Department, Lewiston  
 \*Central Penobscot Public Health Association, Old Town  
 \*South Franklin County Nursing Service, Wilton

**MARYLAND**

\*Metropolitan Life Insurance Nursing Service, Annapolis  
 \*Dorchester County Tuberculosis Association, Cambridge  
 Dorchester County Health Department, Cambridge  
 The Federated Charities, Frederick

**MASSACHUSETTS**

\*Arlington Board of Health, Arlington

\*Visiting Nursing Association of Fitchburg, Fitchburg  
 \*Visiting Nurse Association of Lowell, Lowell  
 \*Watertown District Nursing Association, Watertown

**MICHIGAN**

Metropolitan Life Insurance Nursing Association, Calumet  
 \*City Department of Health, Detroit  
 \*District Nursing Association of Barnstable, Yarmouth and Dennis, Hyannis  
 Metropolitan Life Insurance Nursing Service, Kalamazoo  
 \*Visiting Nurse Association of Saginaw, Saginaw

**MINNESOTA**

Beltrami County Nursing Service, Bemidji  
 Northwest School, Crookston  
 City Health Department, Duluth  
 McLeod County Public Health Association, Glencoe  
 Pine County Nursing Service, Hinckley  
 District Office, Minnesota Department of Health, Mankato  
 \*Hennepin County Rural Public Health Nursing Service, Minneapolis  
 Moorhead Public Schools, Moorhead

**MISSISSIPPI**

Prentiss County Health Department, Booneville

**MISSOURI**

\*Metropolitan Life Insurance Nursing Service, Clayton  
 Missouri State Health Department, District No. 2, Dexter  
 Cass County Health Unit, Harrisonville  
 Chariton County Public Health Nurse, Keytesville  
 Randolph County Public Health Nursing Service, Moberly  
 \*St. Joseph Organization for Public Health Nursing, St. Joseph  
 \*Board of Education, St. Louis  
 \*Municipal Visiting Nurses, St. Louis  
 \*Visiting Nurse Association of St. Louis, St. Louis  
 Miller County Health Department, Tusculumbia

**NEBRASKA**

\*Lincoln and Lancaster County Chapter, American Red Cross, Lincoln  
 Dundy County Public Health Nursing Service, Lincoln

**NEW HAMPSHIRE**

\*Lancaster Chapter American Red Cross, Lancaster

**NEW JERSEY**

\*Metropolitan Life Insurance Nursing Service, Asbury Park  
 \*Central Bergen Visiting Nurse Service, Hackensack

Middlesex County Girls Vocational  
School, Metuchen  
Northern Bergen Nursing Service, Ramsey  
\*State Department of Public Instruction,  
Trenton

**NEW MEXICO**

Catron County Health Department, Beaverhead  
\*Torrance County Health Department,  
Estancia  
\*San Miguel County Health Department,  
Las Vegas  
Catron County Department of Public  
Health, Reserve  
\*New Mexico State Health Department,  
Santa Fe

**NEW YORK**

\*Metropolitan Life Insurance Nursing  
Service, Batavia  
Bronxville Public Schools, Bronxville  
\*Metropolitan Eastern Long Island Nursing  
Service, Hempstead  
\*Metropolitan Life Insurance Nursing  
Service, Kingston  
\*Metropolitan Life Insurance Nursing  
Service, Lancaster  
Metropolitan Life Insurance Nursing  
Service, Middletown  
\*Judson Health Center, New York City  
Metropolitan Life Insurance Nursing  
Service, Nyack  
\*Metropolitan Life Insurance Nursing  
Service, Port Jervis  
\*Metropolitan Life Insurance Nursing  
Service, Poughkeepsie  
Metropolitan Life Insurance Co., Rome  
\*Metropolitan Life Insurance Nursing  
Service, Watertown

**NORTH CAROLINA**

\*Metropolitan Life Insurance Nursing  
Service, Charlotte  
Metropolitan Life Insurance Nursing  
Service, Durham

**NORTH DAKOTA**

Golden Valley County Health Nursing  
Service, Beach  
Bismarck Public Health Nursing Service,  
Bismarck  
Burke County Public Health Nursing  
Service, Bowbells  
Dickey County Public Health Nursing  
Service, Ellendale  
\*Walsh County Public Health Nursing  
Service, Grafton  
Grand Forks County Public Health Nursing  
Service, Grand Forks  
Mencer County Health Department,  
Hazen  
Nelson County Public Health Nursing  
Service, Lakota  
Ransom County Public Health Nursing  
Service, Lisbon  
Mandan Public Health Nursing Service,  
Mandan  
Dunn County Public Health Nursing  
Service, Manning

Hettinger County Health Department,  
Mott  
Rollatte County Public Health Nursing  
Service, Rollatte  
Pierce County Public Health Nursing  
Service, Ruby  
McHenry County Health Nursing Service,  
Towner  
Barnes County Public Health Nursing  
Service, Valley City  
\*City and School Public Health Nursing  
Service, Valley City  
Richland County Public Health Nursing  
Service, Wahpeton

**OHIO**

Pickaway County Public Health Nursing  
Service, Circleville  
Visiting Nurse Association of Cleveland,  
Branch No. 1  
Visiting Nurse Association of Cleveland,  
Branch No. 2  
Visiting Nurse Association of Cleveland,  
Branch No. 3  
Visiting Nurse Association of Cleveland,  
Branch No. 4  
Visiting Nurse Association of Cleveland,  
Branch No. 5  
Visiting Nurse Association of Cleveland,  
Branch No. 6  
Visiting Nurse Association of Cleveland,  
Branch No. 7  
\*American Red Cross Public Health Nursing  
Service, East Liverpool  
Lima Visiting Nurse Association, Lima  
Metropolitan Life Insurance Nursing  
Service, Steubenville  
\*Toledo District Nurse Association, Toledo

**OREGON**

Morrow County Public Health Nursing  
Service, Heppner  
Lake County Public Health Service,  
Lakeview  
Wasco-Shorman Public Health Department,  
Moro  
\*Malheur County Public Health Association,  
Vale

**PENNSYLVANIA**

Metropolitan Life Insurance Nursing  
Service, Altoona  
North Penn Community Centre, Ambler  
Metropolitan Life Insurance Nursing  
Service, Meadville  
Mount Pleasant Chapter American Red  
Cross, Mount Pleasant  
Babies Hospital of Philadelphia, Philadelphia  
\*Visiting Nurse Society of Philadelphia,  
Philadelphia  
Metropolitan Life Insurance Nursing  
Service, Pottstown  
Visiting Nurse Society, Pottstown  
\*Reading Visiting Nurse Association,  
Reading  
Community Health Society of Central  
Delaware County, Swarthmore  
American Red Cross Public Health Nursing  
Service, Vandergrift

**RHODE ISLAND**

- \*Cranston School Health Division, Cranston
- \*North Providence School Department, North Providence
- \*Burrillville District Nursing Association, Pascoag

**SOUTH CAROLINA**

- \*Metropolitan Life Insurance Nursing Service, Greenville
- Newberry County Health Department, Newberry
- Pickens County Health Department, Pickens
- Metropolitan Life Insurance Nursing Service, Spartanburg

**TENNESSEE**

- Health Department, Clarksville
- \*Metropolitan Life Insurance Nursing Service, Knoxville
- \*Metropolitan Life Insurance Nursing Service, Memphis
- \*Davidson County Health Department, Nashville
- \*Metropolitan Life Insurance Nursing Service, Nashville
- \*Gibson County Department of Public Health, Trenton

**TEXAS**

- \*Van Zandt County Health Department, Canton
- \*Dallas Public Schools, Department of School Health Work, Dallas
- Carson County Health Department, Panhandle

**UTAH**

- \*Metropolitan Life Insurance Nursing Service, Ogden

**VERMONT**

- Metropolitan Life Insurance Nursing Service, Rutland

**VIRGINIA**

- \*Metropolitan Life Insurance Nursing Service, Portsmouth

**WASHINGTON**

- \*Metropolitan Life Insurance Nursing Service, Tacoma

**WEST VIRGINIA**

- Division of Crippled Children, West Virginia Department of Public Assistance, Charleston
- \*Metropolitan Life Insurance Nursing Service, Martinsburg

**WISCONSIN**

- Sauk County Health Department, Barabou
- \*Visiting Nurse Service, Madison
- State Teachers College, Superior
- Two Rivers Health Department, Two Rivers
- \*Bayfield County Health Department, Washburn

**WYOMING**

- Fremont County Public Health Nursing Service, Riverton

\*Agencies which have been on the Honor Roll for five years or more.

**News from S.O.P.H.N.'s**

(Continued from page 210)

3. Participation in local nursing activities of the American Red Cross, such as classes in home nursing.
4. Reciprocal organization membership in General Federation of Women's Clubs.
5. Encouragement of interest on the part of local study groups in legislative measures relating to the health of the community.

One of the biggest problems confronting the Organization at the present time is the rapid expansion of industrial plants and the employment of a large number of industrial nurses, many of them male nurses. Some are ex-Navy men, but others are simply called "nurse" by the industrial plant and the employees because they hold a certificate in first aid. The State Organization is now con-

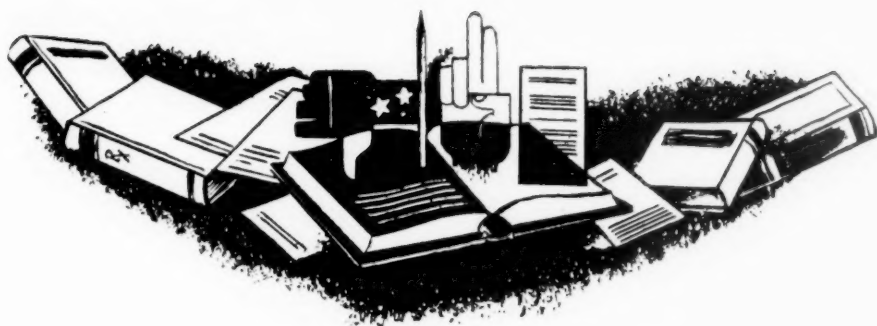
centrating on a membership campaign to inform these nurses of organization objectives, and on an effort to acquaint industries with desirable qualifications for nurses employed in industry.

Two units of the S.O.P.H.N. have industrial nursing sections. At the request of members of the Los Angeles section, an extension course in industrial hygiene has been offered by the University of California, Los Angeles.

Now that adulthood has been reached, the C.S.O.P.H.N. looks forward to the progress and accomplishments which should result from our more mature years.

ANN L. FINCH, R.N.

Chairman, Publicity Committee  
California State Organization  
for Public Health Nursing



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EDITED BY ANNA C. GRING

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#### COMMUNICABLE DISEASE CONTROL

By Gaylord W. Anderson, M.D. and Margaret G. Arnstein, R.N. 434 pp. The Macmillan Company, New York, 1941. \$4.25.

The public health nurse at last has been pictured in her full and fitting sphere in the communicable disease control program. The authors state that this book has been prepared for the use of the health officer and the public health nurse; that it is written from the standpoint of the community with emphasis on protection of the entire population rather than just the individual. They have "... attempted to appraise the practical value of various control measures and have been led to discard or minimize the importance of many as yielding too few returns in terms of the severity of the problem and the expense involved."

The book is divided into two parts. The first presents a general discussion of control measures; the second gives details in regard to specific diseases. The chapter, *Role of the Public Health Nurse*, gives a concise picture of the opportunities of every community nurse—whether she be a school nurse, visiting nurse, or health department nurse—in communicable disease control.

Every public health nurse will turn to the chapter on *Care of a Communicable Disease Case at Home*. The plea is made that "... techniques should

change with new knowledge" and that the care of each disease in each home situation must be considered individually, though guided by certain principles. Controversial subject matter is treated simply and in a manner so reasonable and logical that many agencies will view existing techniques through new eyes, and students meeting this kind of subject matter for the first time will not be overwhelmed.

Important points in nursing care of specific diseases are presented, including material on details of bedside care, the number of nursing visits necessary, and the function of the nurse in relation to that of the health and sanitary officers in the administrative plan. It is stimulating to note that precedence is given to the actual care and comfort of the patient; methods of isolation and quarantine are given as additional responsibilities in natural sequence.

The material is presented clearly and with sufficient detail to be useful. The bibliographies at the end of each chapter are comprehensive. Important factual material is presented in an interesting manner, with emphasis throughout on the coöperative management of a communicable disease program and on the necessity for review of procedures in the light of new knowledge and needs.

MARION A. FLUENT, R.N.  
Cleveland, Ohio

### HOUSING FOR HEALTH

Papers presented under the auspices of the Committee on the Hygiene of Housing of the American Public Health Association. 221 pp. The Science Press Printing Company, Lancaster, Pennsylvania, 1941. \$1.

All of the papers presented in this book have interest for public health nurses, but particularly stimulating are Dr. C.-E. A. Winslow's article, "Health and Housing," an article by John C. Leukhardt on "Health Centers and Health Services in Housing Projects," Frederick J. Adams' "Planning for Recreation," Dr. Svend H. Riemer's "Family Life as the Basis for Home Planning," and Dr. F. Stuart Chapin's "Social Effects of Good Housing."

Perusal of these papers should widen our perspective on the subject of housing, sharpen our observations, and give greater substance to our contribution to this newest field of public health.

ELIZABETH G. FOX, R.N.  
*New Haven, Connecticut*

### PHYSICAL FITNESS

Supplement to The Research Quarterly of the American Association for Health, Physical Education, and Recreation, 493 pp. Springfield College Studies, Division of Health and Physical Education, Springfield, Massachusetts, 1941. Paper cover \$1, Cloth cover \$1.75.

"Physical fitness" is a term much used—and abused—especially during times of national crisis. As long as we define the manner in which the term is used, confusion may be minimized and an understanding of its true nature achieved.

This monograph contributes to such clarification. Aspects of physical fitness are delineated. These include anthropometric considerations such as body build, weight and tissue symmetry, and posture; neuromuscular qualities associated with performance of motor skills such as flexibility, strength, and coordination; physiological effects of exercise as shown in studies of fatigue, endurance, metabolism, and cardiovascular-respiratory relationships; and mental hygiene.

Each of these aspects is a complex—

the exact nature of which has not yet been determined. Continuous research is, however, in progress. This monograph summarizes recent investigations in each of the areas suggested above and contributes results of original studies.

For the educator and public health worker interested in clarifying his concept of physical fitness or in pursuing research in this area, the monograph should prove very helpful. The bibliography accompanying each chapter is especially rich.

MABEL E. RUGEN, Ph.D.  
*Ann Arbor, Michigan*

### CHILDREN IN THE FAMILY

By Florence Powdermaker, M.C. and Louise Ireland Grimes. 403 pp. Farrar & Rinehart, Inc., New York, 1940. \$2.

This book describes the way we grow from birth through adolescence. In non-technical language, the authors emphasize emotional and personality development of the child in a clear, simple, and direct manner. Parents who read this book will gain useful information and will increase their understanding of relationships. They will be helped to feel that they can become successful parents. The book expresses a helpful and constructive attitude toward problems presented by parents. Every nurse should include it among her essential readings.

IRENE CARN, R.N.  
*New York, New York*

### THE PARENTS MANUAL

By Anna W. M. Wolf. 331 pp. Simon and Schuster, New York, 1941. \$2.50.

In this book Mrs. Wolf shows a knowledge of the parents' needs for help in understanding the emotional and social growth of the child. She advances no new theories, but shows an understanding of present concepts in her presentation of the child's emotional development and his building of relationships with other members of the family. Concrete suggestions are given for the handling of various behavior



symptoms such as thumb-sucking, temper tantrums, and stuttering. Reassurance is given to the parents by presenting both sides of questions, and emphasizing individual differences. The chapter, *The Forgotten Father*, as well as other parts of the book, show the importance of parental attitudes in the care and training of children. The book has much more value for lay readers than for professional workers.

BESS HAWVER, R.N.  
*Chicago, Illinois*

#### PROCEEDINGS OF THE NATIONAL CONFERENCE ON SOCIAL WORK

Selected Papers, Sixty-Eighth Annual Conference  
Atlantic City, New Jersey, June 1-7, 1941. 787  
pp. Columbia University Press, New York. \$5.

This volume of 64 papers selected from 150 of those presented at the National Conference of Social Work will be of particular interest to administrators, supervisors, and instructors of public health nursing. It is essentially a reference book. Some of the subjects discussed are various aspects of national defense and labor migration, the theory and practice of case work, the role of the board member, the care of children, health and housing, and the care of the handicapped.

ANNA C. GRING, R.N.  
*Washington, D.C.*

#### EYE HAZARDS IN INDUSTRY

By Louis Resnick. 321 pp. Columbia University Press, New York, 1941. \$3.50.

This is an interesting, well illustrated, and informative book. It is, I believe, the only book of its kind, and should be in the library of every safety engineer. A great deal of credit is due to the late Mr. Resnick for undertaking so comprehensive a manual, much of which must have been done during his final illness. It is to be regretted that some parts of the book were not more carefully edited. When the author writes of accidents, accidental injuries, and their control and prevention, he is on sure ground; but the

chapters on eye diseases, defective vision, first aid, and workmen's compensation laws have a good many inaccuracies and are marred by loose writing.

ANTHONY J. LANZA, M.D.  
*New York, New York*

#### TUBERCULOSIS NURSING

By Grace M. Longhurst, R.N. 280 pp. F. A. Davis Company, Philadelphia, 1941. \$3.

All nurses who are interested in the care of the tuberculous patient will welcome this book. It fills a long felt need. Miss Longhurst states that: "The new concept of treatment has created a demand for nurses whose fundamental training has fitted them for medical, surgical, communicable disease, and mental nursing," and that "The aim of the tuberculosis nurse is to nurse the whole patient." The subject matter is comprehensive and well organized. Modern concepts in the field of tuberculosis and their implications in tuberculosis nursing are discussed.

The selected references at the end of each chapter should prove helpful. Most noteworthy are the clear and practical illustrations and graphic sketches.

The book is written primarily for nurses interested in the institutional care of the tuberculous patient. However, many aspects of tuberculosis nursing in the field of public health are discussed.

GOLDA B. SLIEF, R.N.  
*Oklahoma City, Oklahoma*

#### WE WHO SERVE—A STORY OF NURSING IN VERMONT

The Vermont State Nurses' Association, 3 Nelson Street, Montpelier, Vermont, 1941. 125 pp. \$2.

This is another of the historical sketches being published by the state nurses' associations. Each is a contribution to nursing literature; each marks a milestone in the work of the particular state association.

*We Who Serve* contains personal reminiscences about nursing in Vermont, summaries of the work of various groups and institutions, and a chronology of certain developments. No attempt is

made to relate or parallel the developments in nursing with those in the social and economic life of the people in the state. The Vermont State Nurses' Association is to be congratulated on having brought out this book under such difficult circumstances. The project has been going forward since 1931, and is almost entirely the work of volunteers.

HELEN W. MUNSON, R.N.  
*New York, New York*

#### TWO BOOKLETS ON MATERNAL CARE

**Maternal Care Complications.** Edited by F. L. Adair, M.D. 93 pp. The University of Chicago Press, Chicago, second edition revised, 1941. 60c.

**Maternal Care.** Edited by F. L. Adair, M.D. 92 pp. The University of Chicago Press, Chicago, second edition revised, 1941. 60c.

*Maternal Care Complications* is a companion to *Maternal Care*. It deals with the three great causes of maternal mortality—the toxemias of pregnancy, obstetric hemorrhages, and puerperal infections.

The section on the toxemias of pregnancy includes a very clear and brief presentation of the classification of toxemias as adopted by The American Committee on Maternal Welfare. This classification appears in the second edition, but not in the first. In both editions we find emphasis on the following statement, "too much emphasis cannot be placed upon the importance of treating the disease first and terminating the pregnancy later."

Puerperal infection is considered the most avoidable of the three great causes of maternal mortality. The medical profession, the medical schools, the hospitals, and finally the laity are all charged with the responsibility for reducing mortality from this cause.

The importance of obstetric hemorrhage is emphasized by the fact that nearly one half of the book is devoted to the subject.

The purpose of the booklet entitled *Maternal Care* is stated in the preface, "... to set forth in simple and concise

form some of the basic principles of maternal care." That purpose is fulfilled.

The book is easy to read and easy to understand. It is to be recommended for the medical and allied professions in instances where the individual will not or cannot take time to read extensively on the subject, or for the individual who is not up to date in his reading. This does not by any means conclude its usefulness. There is a great deal of advice and instruction worth anyone's time.

There is very little difference in the size and outward appearance of the first and second editions. On close inspection, however, it will be noted that the arrangement is greatly improved in the latter, and additional headings add to its convenience. The second edition also has a table of contents which makes it more usable.

PERCY F. GUY, M.D.  
*Seattle, Washington*

#### DOCTORS DON'T BELIEVE IT—WHY SHOULD YOU?

By August A. Thomen, M.D. 384 pp. Simon and Schuster, New York, 1941. \$2.50.

This is an absorbing book, presenting many interesting facts and fallacies about health, with practical guidance for the layman. The approach is through 254 questions. The first question is, "Which should be most thoroughly chewed—meat, bread, vegetables, or fruit?" The last question is, "What is the 'death agony' we hear so much about?" The few points of difference which the reviewer has with Dr. Thomen are of such a nature that they require no discussion in a brief review of this type. The book is written in a pleasing style, and is mostly free from technical discussion and terminology. It should prove useful not only to the layman, but to those professionally interested in the medical sciences. The reviewer recommends it heartily.

H. B. HAAG, M.D.  
*Richmond, Virginia*

## COMING OF AGE

By Esther Lloyd-Jones, Ph.D., and Ruth Fedder, Ed.D. 280 pp. McGraw-Hill Book Company, Inc., New York, 1941. \$2.50.

For adults who work with young people and for young people themselves this book should prove a valuable guide. The beginning chapters discuss in an interesting manner the development and needs of the personality, family relationships, and the ever absorbing subject of men, women, and marriage. Other chapters deal with the choosing of a satisfactory vocation, and the part played by college in preparation for life. This section is particularly helpful because of contributions made by a number of young people.

Statistics regarding academic attainment and opportunities for employment for young people bring to our attention many of the problems faced by youth in this modern world.

The last chapter of the book, *What Can We Believe*, deals with personal

satisfactions and spiritual values, with suggestions for attaining satisfactory goals in living.

REBA EDWARDS, R.N.  
*Spreckels, California*

## INFANTILE PARALYSIS

By Philip Lewin, M.D. 372 pp. W. B. Saunders Company, Philadelphia, 1941. \$6.

Although this book is written primarily to assist the physician in the early recognition and treatment of infantile paralysis, it is a useful reference text for nurses. All aspects of the disease and principles and methods of treatment are included. It is clearly written and well illustrated, and contains an excellent bibliography. Some of the sections of most interest to nurses are those dealing with the status of serum therapy, care in the respirator, orthopedic appliances, care in the home, and a brief explanation of the Kenny treatment.

J.L.S.

## RECENT PUBLICATIONS AND CURRENT PERIODICALS

## HOUSING

PROCEDURE FOR THE MAINTENANCE OF HOUSING STANDARDS IN MILWAUKEE. Charles L. Senn. Reprint No. 2228 from Public Health Reports. Superintendent of Documents, Washington, D. C., 1941. 9 pp. 5c.

Close coöperation between the health department and the building inspection department in Milwaukee is bringing about an improvement in standards of existing housing facilities of low-income families and families on relief, pending the time when better dwellings will be made available through housing projects.

ACCIDENTS IN THE URBAN HOME AS RECORDED IN THE NATIONAL HEALTH SURVEY. Rollo H. Britten, Joan Klebba, and David E. Hailman. Reprint No. 2207 from Public Health Reports. Superintendent of Documents, Washington, D.C., 1940. 26 pp. 5c.

A report summarizing data collected in the National Health Survey on serious home accidents in 700,000 families in 83 cities in the United States. Particularly interesting is the relationship which apparently exists between

home accidents and poor economic status, and between home accidents and poor housing. Study shows importance of home accidents as a cause of disability, particularly among children and adults in the most productive ages. "... Many of the persons surveyed had permanent orthopedic impairments or were blind as a result of home accidents."

RECENT DEVELOPMENTS RELATING TO PUBLIC HEALTH INTEREST IN HOUSING. John C. Leukhardt. Public Health Reports, April 25, 1941, p. 871. Superintendent of Documents, Washington, D. C. 5c.

STUDY OF HOME ACCIDENTS: THEIR PUBLIC HEALTH SIGNIFICANCE. Donald B. Armstrong and W. Graham Cole. *American Journal of Public Health*, November 1941, p. 1135. American Public Health Association, 1790 Broadway, New York, N.Y.

This article contains tabulations of a study on home accidents made by nurses of the Metropolitan Life Insurance Company in 1940 and suggests opportunities for the health departments in prevention of home accidents.

**PLANNING FOR SAFETY.** A discussion of in-built safety provisions in the layout of sites and the design and construction of buildings and utilities for low-rent housing. Federal Works Agency, United States Housing Authority. Superintendent of Documents, Washington, D. C., 1941. 22 pp. 15c.

**THE HOUSING PROBLEM AS IT AFFECTS PUBLIC HEALTH NURSING ACTIVITIES.** Mary J. Dunn. Reprint No. 2202 from *Public Health Reports*. Superintendent of Documents, Washington, D. C., 1940. 6 pp. 5c.

#### DEFENSE

**SAFETY CLOTHING FOR WOMEN IN INDUSTRY.** Special Bulletin No. 3 of the Women's Bureau, U. S. Department of Labor. The Superintendent of Documents, Washington, D.C., 1941. 10c.

**REDUCTION OF COMMUNICABLE DISEASES AMONG TROOPS AND CHILDREN DURING NATIONAL DEFENSE PROGRAM.** Wilburt C. Davison, M.D. *War Medicine*, November, 1941. The American Medical Association, Chicago. \$1.25 single copy. Bi-monthly. \$5 annual subscription.

A good resumé of some of the problems of communicable diseases under wartime conditions, and measures for their prevention or control.

**THE DEFENSE OF CHILDREN SERIES:** Children Bear the Promise of a Better World. Superintendent of Documents, Washington, D.C., 1942. \$3 per hundred.

1. What Are We Doing to Defend Them?
2. Are We Safeguarding Those Whose Mothers Work?
3. Are They Getting the Right Start in Life?
4. Have They the Protection of Proper Food?
5. Are We Defending Their Right to Health?
6. Their Defense Is the Security They Find at Home.
7. Their Education Is Democracy's Strength.
8. Through Play They Learn What Freedom Means.
9. Our Nation Does Not Need Their Toil.
10. Are We Helping Those With Special Needs?
11. Protect Them from Harmful Community Influences.

**TWELVE MONTHS OF HEALTH DEFENSE.** John L. Rice, M.D., Health Commissioner. 283 pp. New York City Department of Health, 125 Worth Street, New York, N.Y., 1941. \$1. Executives of both official and nonofficial

public health nursing agencies will find this report stimulating and helpful.

#### ORTHOPEDIC NURSING

**THE TREATMENT OF INFANTILE PARALYSIS IN THE ACUTE STAGE.** Elizabeth Kenny. Bruce Publishing Company, Minneapolis, St. Paul. 1941. \$3.50.

Chapter IV on the Kenny method of application of fomentations should be of particular interest to all public health nurses.

**THE FOOT AND ANKLE.** Philip Lewin, M.D. Lea & Febiger, Philadelphia, 1941. 665 pp. \$9.

This book is primarily a guide for medical practitioners, but it is an excellent reference for nurse physical therapists and orthopedic nurses. The appendix on "Footnotes and Footsteps—Pedigrams" is of interest and value to both lay and professional groups.

#### GENERAL

**SEVEN PAMPHLETS** published by the Bureau of Health and Public Instruction, American Medical Association, Chicago, 1941.

**Visual Efficiency** by Henry A. Imus. Single copy 10c.

**Cancer Control** by Frank E. Adair. Single copy 10c.

**Sex Education for the Preschool Child** by Harold E. Jones and Katherine Read. Single copy 15c.

**Sex Education for the Ten Year Old** by M. Marjorie Bolles. Single copy 15c.

**Sex Education for the Adolescent** by George W. Corner and Carney Landis. Single copy 15c.

**Sex Education for the Married Couple** by Emily Hartshorne Mudd. Single copy 15c.

**Sex Education for the Woman at Menopause** by Carl G. Hartman. Single copy 15c.

**SOCIOLOGY AND SOCIAL PROBLEMS IN NURSING.** Gladys Sellow, Ph.D., R.N. W. B. Saunders Company, Philadelphia, 1941. 344 pp. \$2.75.

Although intended for students in schools of nursing, this book will prove useful to public health nurses because of its interpretation of the family, rural life, housing, and the social security program in the United States.

**DRAMATIZATION IN SAFETY EDUCATION.** National Education Association, 1201 Sixteenth Street, N.W., Washington, D.C. 56 pp. 25c. Other leaflets on safety are also available.

# NEWS

## Highlights on Defense

### CHILD HEALTH DAY—1942

**T**HE Child Health Day Proclamation issued by the President is the opening gun in a campaign to have all children in the United States immunized against smallpox and diphtheria before May 1, which since 1928 has been designated by Act of Congress as Child Health Day:

WHEREAS the Congress by joint resolution of May 18, 1928 (45 Stat., 617), has authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day:

NOW, THEREFORE, I, FRANKLIN D. ROOSEVELT, President of the United States of America, in recognition of the vital importance of the health of children to the strength of the Nation, do hereby designate the first day of May of this year as Child Health Day.

And I call upon the people in each of our communities to contribute to the conservation of child health and the reduction of illness among children by exerting every effort to the end that before May Day, Child Health Day, children over nine months of age be immunized against diphtheria and smallpox, the two diseases for which we have the surest means of prevention.

In witness whereof I have hereunto set my hand and caused the seal of the United States of America to be affixed.

FRANKLIN D. ROOSEVELT  
*February 6, 1942*

### EVERY NURSE RECRUIT A NURSE

**E**VERY NURSE recruit a nurse! In this critical period when the number of nurses must rise rapidly to keep pace with the national need, the goal of "fully 50,000 well qualified students to enter schools of nursing this year" will not be reached without intensive work on the part of every nurse. Public health nurses, with their varied community contacts, can be especially helpful.

While much can be done through com-

mittee participation, the Committee on Recruitment of Student Nurses of the Nursing Council on National Defense urges a vigorous campaign of personal recruiting by each individual nurse who is interested in her work and fully aware of its essential value to the nation.

Nurses who have college contacts are urged to use them. Nurses can talk to their local alumnae. They can go back to college reunions this spring, and talk about the need for nurses—perhaps try to get the subject on one of the regular programs. Sorority members can recruit among undergraduates and alumnae in the same way. Younger nurses, not too far from their high-school days, can go back and visit their schools as opportunity affords, letting students and teachers know that the best of the senior girls are wanted for the profession of nursing.

Plans for public speaking or organized recruiting should be cleared, of course, with the local or state recruitment committee, but individual recruitment is the obligation of every nurse. To enlist a good recruit is to contribute to national victory.

### RED CROSS ACTIVITIES

**I**T IS ESTIMATED that a total of about 21,000 nurses will be needed to care for an army of three and one-half million men. Although enrollment in the Red Cross Nursing Service in February reached 3000, an all-time peak—of which 2000 were in the First Reserve—this only leaves a remaining reserve of about 18,000 nurses as yet unassigned. The rate of enrollment will have to be rapidly stepped up if we are to provide our armed forces with the care they need. We must have a First Reserve of at least 50,000.



The activation of general and evacuation hospital units for overseas service has greatly stimulated enrollment. According to a directive from the Surgeon General's office, "only nurses in the American Red Cross First Reserve are eligible for such an assignment."

All nurses eligible for service with the armed forces should complete their enrollment in the Red Cross Nursing Service now so that they will be ready for assignment abroad or on the home front.

**A** MOTION PICTURE, "Before the Doctor Comes," has been prepared by the American Red Cross for use in its nationwide wartime program of first aid training.

The film demonstrates proper first-aid procedures to be employed at the scene of accident, including control of bleeding, artificial respiration, care of shock, application of traction splints for leg and arm fractures, care of burns, and methods of transportation of the injured.

Each of the four reels is complete in coverage of its subject, permitting use of the film in its four parts. The entire picture takes 37 minutes screening time and is available in both sound and silent versions for 16 mm. projectors.

The movie will be used as a teaching aid in the instructor-training courses now being conducted throughout the country by Red Cross staff men. It will also be made available to local Red Cross chapters and other groups and organizations for use in the standard and advanced first-aid courses, in which the public is now enrolling at a rate of more than 40,000 a day.

**T**HE American Red Cross and United Service Organizations, Inc., have issued a joint statement defining the services which each organization renders to the nation's armed forces. According to this statement, the Red Cross is responsible for welfare service to units of the armed forces in garrison or on active duty in the field or proceeding in

transit as members of an organized body under orders. It is also responsible for social service and recreational programs in military and naval hospitals.

Primary responsibility of the USO is to serve members of the armed forces wherever they are off duty or on leave, these services being of "a religious, social, and recreational character."

**T**HE American Red Cross is prepared to expedite shipments of food and clothing to prisoners of war and non-combatants interned by the Japanese government as soon as the "go ahead" signal is received from Japan. The Japanese government has accepted the appointment of a delegate of the International Red Cross Committee, and the Japanese Red Cross has offered to assist the delegate in arranging distribution. These supplies will supplement the food and clothing which the Japanese are to provide American military prisoners and civilians.

United States postal authorities have indicated that personal packages to prisoners of war will be handled free of charge through the regular postal channels as soon as the correct addresses of the recipients can be obtained.

The American Red Cross will also seek information through the International Red Cross concerning missing Americans whose names do not appear on the official prisoners-of-war lists. First reports concerning prisoners of war and interned civilians will be supplied to their next of kin by the Prisoners of War Information Bureau of the War Department. This list will be obtained both by representatives of the Swiss Government and the delegate of the International Red Cross.

**A** CONTRIBUTION of \$25,000 with which to finance blood transfusions and other urgent medical relief for war victims in the Dutch East Indies was cabled by the American Red Cross to the Netherlands East Indies Red Cross in Bandoeng, Java, on March 4.

## DISTRIBUTION OF NURSES

**K**ATHARINE TUCKER has accepted the chairmanship of a Committee on Supply and Distribution of the Nursing Council on National Defense, which is to work with state and local nursing councils on the finding and selective distribution of nurses in accordance with military and civilian needs.

## MEETING OF NURSING COUNCILS

**A** JOINT MEETING of representatives of state nursing councils on defense was held in Chicago, Illinois, March 23 and 24, under the sponsorship of the Subcommittee on Nursing of the Health and Medical Committee and the Nursing Council on National Defense. Consultants from federal and national agencies presented various aspects of nursing in war, including plans for recruitment and education of students in schools of nursing, military and civilian nursing service in the emergency, use of auxiliary nursing service and volunteers, and the program of the Medical Division of the United States Office of Civilian Defense. Following these sessions, conference meetings were held in which the part of state nursing councils in all phases of these programs was discussed.

## NUTRITION MATERIALS

**A** NUTRITION poster including the official symbol and slogan of the national nutrition program and explaining what foods to eat for health and victory has been issued by the Office of Defense Health and Welfare Services, Washington, D.C. Copies are available free of charge upon request.

"Proof of the Pudding" is a ten-minute motion picture in technicolor, with sound, presented by the Metropolitan Life Insurance Company and the United States Public Health Service. This one-reel picture is available in 35 mm. sound (nitrate stock only) and in 16 mm. sound. The 35 mm. print can only be

shown in a safety booth which is in keeping with the local fire laws. The picture can be used for school and community health education programs. It can also be shown in local theaters. It is available free of charge from the Welfare Division of the Metropolitan Life Insurance Company, 1 Madison Avenue, New York, N.Y.

## MORE FUNDS FOR EDUCATION

**F**URTHER federal funds were made available for the education of nurses for national defense, when a deficiency appropriation bill for \$600,000 was signed by the President on February 25. These funds are to be administered by the United States Public Health Service.

## STATE NURSING COUNCILS

**C**HANGES in the list of secretaries or chairmen of state nursing councils on defense and additions since the list was published in the February issue, page 111, are given below. The names may be those of *either* the chairmen or the secretaries.

**Arkansas**

Mrs. Mary T. Wright, 5404 T. Street, Little Rock

**Connecticut**

Marion H. Douglas, 57 Forest Street, Hartford

**Georgia**

Durice Dickerson, 131 Forrest Avenue, N. E., Atlanta

**Idaho**

Nellie J. Chapman, St. Luke's Hospital, Boise

**Missouri**

Louise Knapp, 416 South Kingshighway, St. Louis

**Montana**

Sister M. Germaine, Sacred Heart Hospital, Havre

**Nevada**

Josephine Reeve, 339 West First Street, Reno

**Ohio**

Mrs. Elizabeth P. August, 50 East Broad Street, Columbus

**Utah**

Vera Klingman, 130 State Capitol Building, Salt Lake City

**Wisconsin**

Mrs. Edith M. Partridge, 3727 East Layton Avenue, Cudahy

**Hawaii**

Mrs. T. L. Gage, Mabel L. Smyth Memorial Building, 510 South Beretania Street, Honolulu

## *From Far and Near*

- A monthly bulletin board poster service has been initiated by the National Tuberculosis Association beginning with the release of a set of four posters 8½ x 11 inches, in two colors, illustrating the need for precautionary health measures. The posters are available through local tuberculosis associations.
- National Boys and Girls Week will be celebrated throughout the United States from April 25 to May 2, in an effort to focus the attention of communities upon boys and girls—their problems, activities, and training—and to enlist the coöperation of all agencies and individuals in a year-round program to meet the needs of the coming generation.
- The twenty-eighth observance of National Negro Health Week, April 5-12, will emphasize the opportunities in the national defense program for the improvement of community health. This movement, begun by Booker T. Washington and originally known as Health Improvement Week, was started as a means of making the Negro conscious of his health and has increased in scope over the past quarter of a century. All communities having a Negro population are asked to help promote the movement by taking an active part in the observance of this week.
- Annual state meetings to be held in the next few months include the following:
  - Iowa Public Health Association, Des Moines, April 13-14. (The Iowa S.O.P.H.N. will have charge of the luncheon meeting on April 13.)
  - Iowa State Association of Registered Nurses, Fort Dodge, October 7-9.
  - New Mexico State Nurses Association, Las Vegas, May 28-30.
  - Ohio State Nurses' Association, Columbus, May 8-9.
  - Texas State Organization for Public Health Nursing, San Antonio, April 14-16.
- Safeguarding the health of mothers and babies is one of the most important aspects of civilian defense in a nation at war. Public health nurses are therefore especially interested in the Second American Congress on Obstetrics and Gynecology—to be held in St. Louis, Mo., April 6-10—which will bring them up to date on the latest scientific developments and newer methods in this important field of nursing. One great value of the Congress is that it brings together all the various professional workers interested in maternal and infant care. The registration fee of \$5 entitles the registrant to a membership in the American Committee on Maternal Welfare and a year's subscription to *The Mother*, its quarterly bulletin. Applications for registration should be sent to The Second American Congress on Obstetrics and Gynecology, 650 Rush Street, Chicago.
- The fifth annual meeting of the National Conference of Governmental Industrial Hygienists will be held in Washington, D.C., April 9-11, 1942. The first two days of the conference will be held in the Social Security Building Auditorium. The Saturday meeting will be an informal one held at the Division of Industrial Hygiene, National Institute of Health, Bethesda, Md. Information about the conference can be secured from J. J. Bloomfield, secretary-treasurer, at this address. Anyone concerned with industrial health will be welcome.

### NEW APPOINTMENTS

Bertha Knipfer, Supervisor, Venereal Disease Service, The Nashville Public Health Nursing Council, Tennessee.

Goldie M. Davis, Second Field Advisory Nurse, Oklahoma State Health Department, Oklahoma City.

Joan Y. Ziano, Consulting Nurse for Industrial Hygiene, Division of Industrial Hygiene, Illinois State Department of Public Health, Chicago.

• The U. S. Civil Service Commission announces an open competitive examination for the position of junior public health nurse at a salary of \$1800 a year. The duties of this position are "to perform, under nursing supervision, general public health nursing duties in extracantonment zones and in areas where large defense industries are located and in Indian communities." Applicants will be asked to file a statement concerning their qualifications. In addition to basic nursing qualifications specified in the announcement of the examination, applicants must have successfully completed at least one academic year of study in public health nursing at a college or university offering a program of study approved by the National Organization for Public Health Nursing. A year of supervised experience in general public health nursing may be substituted for half of the academic year's study. Applicants must not have passed their forty-fifth birthday on the date of receipt of application. Provision is made, however, for the waiver of age and physical requirements for temporary

positions connected with the national defense program.

Other information regarding requirements for this position may be secured, together with application forms, from the Commission's representative at any first- or second-class post office or from the central office in Washington, D.C.

• Merit examinations on the following positions are to be held by the Wyoming Merit System Council:

*Unassembled*

Positions of Director, Public Health Nursing—\$200 to \$225 per month; Physical Therapy Consultant—\$160 to \$175; Physical Therapy Technician—\$135 to \$160.

*Written*

Positions of Public Health Nursing Consultant in a Special Field—\$175 to \$200; Senior Public Health Nurse—\$160 to \$180; Public Health Nurse—\$135 to \$160; Junior Public Health Nurse—\$125 to \$135; Emergency Public Health Nurse in Training—\$100 to \$120.

Wyoming residence has been waived for each of these classes. In making appointments, however, preference may be given to Wyoming citizens. Final date for filing applications in the office of the Merit Supervisor, Newcastle, Wyoming, is May 2.

### Clean Apron for Each Visit

(Continued from page 217)

that this technique for cleansing the apron is safe.

Should the need arise, this apron can be soaked in a solution of izal, 1:200—which is the nearest English equivalent to lysol. It can also be boiled. Both of these procedures remove some of the glossy finish—which, while not making the apron pervious to moisture, does shorten its life. It should not be autoclaved. The question might be asked, "Do solutions often used by nurses in the home stain this apron?" So far only three have been tried out—ink, tincture of iodine, and acriflavine, 1:2000. The first two were washed out very easily, while the latter left only an almost imper-

ceptible trace of yellow. Therefore, it would seem unnecessary to consider the staining possibility as a deterrent.

However, there is one serious drawback—the apron's weight, which is about two ounces more than the average cotton apron. The cleansing equipment adds another two ounces. But perhaps we can eliminate needless weight in some other way.

This material may also be secured in black in a somewhat heavier grade which makes an admirable bag lining, and has obvious advantages over the heavy rubber and canvas linings we have used before.

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NOTE: Information regarding the apron described here is given on advertising page 9.

# Our Readers Say . . .

## A LETTER FROM HONOLULU

**B**Y THIS TIME you have read the reports about Pearl Harbor. From the movies and the pictures in magazines, I judge Honolulu itself was the scene of more activity than I had realized. Our house is on the side of a hill which is largely army property. We can't see Pearl Harbor, which is on the other side of the hill. We were peacefully sleeping, not aware of any excitement until I got up to find our morning paper had not arrived. When I took up the receiver to call about it, I overheard a sailor telling someone that a Japanese submarine had appeared in the harbor and complaining because it had to come on Sunday, his only day of rest. "I'll call you when this blows over," said he. Then the radio went off and we knew it had come. Those first few weeks were hectic.

About noon I was asked to be ready for call. About 7:30 p.m. I was told to report to one of the first-aid units. By this time full blackout was in force and while I waited in our front yard for someone to call for me, I saw what I thought were falling stars—but which turned out to be incendiary bombs, anti-aircraft shot, and the like. Driving in complete darkness without lights was somewhat slow and complicated. We were stopped at almost every block and asked who we were and where we were going; for by this time every place was guarded by regular police, home guards, R.O.T.C. men, and recruited volunteers—and they did not stand for any foolishness. Their guns were cocked for use. We got lost, had two or three narrow escapes from collision, and finally landed at the waterfront where everything was popping. While we waited for the raid to be over, we joined the men who were defending the waterfront, in having coffee and soup. When the moon came up, we proceeded and landed at our assigned first-aid unit about 10:00 p.m.—2½ hours after we had started.

About one-half hour later, the first of 350 evacuees began arriving at the station. We had to stow away women and children and even cats and dogs in school rooms on tables and chairs—without blankets, mattresses, or cots. They were all good sports and we had plenty of help from boy scouts and volunteers. For two weeks I worked there from 6:00 p.m. to 6:00 a.m., with little to do after the evacuees left. Then the units were put on a permanent basis to await another emergency and I went back to the university. There I found most

of the faculty engaged in enumerating and fingerprinting the residents of Oahu. We are now required to carry our identification card with us all of the time. I started teaching two daily classes in home nursing, largely for students stranded on the campus.

**W**E LIVE from day to day—that is, from 6:00 a.m. to 6:00 p.m. Most of that time is spent in standing in line for something. At first it was for food because they limited food purchases until an inventory of what was on hand could be completed. Then came waiting for gas masks, fingerprinting, and gas-ration cards. Next it will be for steel helmets. We are fined if we don't have our gas masks with us at all times. I suppose the same will be true of the helmets. After all, there is no use in giving them to us unless we do have them with us constantly.

At 6:00 every evening, the announcer says: "Blackout time—blackout everybody." And everybody does! Lights are shot out without question if they are seen, and fines are passed out. We close ourselves in until daylight. No one is allowed on the streets for any purpose unless he has an authorized pass. We are all catching up on our sleep. When we go out now it is to spend the night. None of us has been working so much harder than usual, but one gets much more tired and tense living under blackout and martial law conditions.

Bomb shelters are cropping up everywhere, ranging from open ditches to elaborate rooms. The ingenious and optimistic souls have bars, electric lights, and the like.

Our Christmas was subdued but pleasant. Some packages had arrived. We exchanged other simple gifts. We had plenty of fowl and trimmings, so it was quite festive—even though we barked our shins and bumped our noses in the blackout. We had a second Christmas when the mail arrived week before last. Our diet is simple because we cannot get all kinds of foods, but we have enough to eat.

Now that what we thought couldn't happen here has happened, I suggest you all take part in whatever defense preparation or training plans you can. I didn't join a first-aid unit before the attack, and therefore had to step into one without knowing anything about the setup. My contribution would have been much more valuable had I been prepared for it.

VIRGINIA A. JONES, R.N.  
Honolulu, Hawaii



# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## Important Meeting on Nursing in the War

THE URGENT problems now facing nurses in relation to the war were discussed by representatives of nursing councils on defense from every state in the Union at a meeting called by the Subcommittee on Nursing and the Nursing Council on National Defense in Chicago on March 23 and 24. Participating were the state executive secretaries—whose expenses were paid from federal funds obtained by the Subcommittee; council chairmen and other representatives sent by many states; nurse representatives from federal and national agencies; and government officials concerned with nursing in the war. The program and the needs for nursing in the war were presented by national speakers, interspersed with free and informal discussion of problems faced by the states and local communities.

The keynote of the meetings was sounded by Mary Beard at the opening session: Not only is it the *responsibility* of nurses to meet the many and urgent demands made on them by the war, but even more it is their *right* to do so—a right which they are determined to exercise. The government's responsibility in regard to nursing was presented by Mary E. Switzer, assistant to administrator, Federal Security Agency. Nursing organization for defense and the relationship of the nursing councils—national, state, and local—to the Subcommittee on Nursing and the Office of Civilian Defense, with its Emergency Medical Committee and its nurse consultant, were explained by Alma C. Haupt, executive secretary of the Sub-

committee. One chart showing the organization of nursing in national defense was reproduced in PUBLIC HEALTH NURSING, March 1942. (Page 149.) Another, shown by Miss Haupt, is to be made available to all state councils soon. (See page 286.)

Problems of organization in state nursing councils on defense—their purpose, membership, functions, and operation—were discussed by the group under the leadership of Mrs. Elmira B. Wickenden, executive secretary of the Nursing Council on National Defense. Among these problems is the very practical one of how the work can be financed. Various sources of funds have already been tapped, including the state nursing organizations themselves, state defense councils, health departments, hospitals, the American Red Cross, and the contributions of interested citizens. A combination of funds secured from government and from private sources, including nursing organizations, was considered the best plan, in order that nurses may be in a position to manage nursing affairs.

An exhibit of plans for civilian protection and care in case of air raids or other incidents due to enemy action was shown at the City Department of Health. One important point illustrated was the way in which medical services are integrated with other protective services such as those of fire, rescue, and demolition squads. Plans for emergency medical care were explained in detail by Dr. W. Palmer Dearing, assistant chief medical officer, and Marian G. Randall, nursing consultant, in the Medical Divi-

sion, Office of Civilian Defense. Nurses were urged to read all publications from the OCD and to apply to state and local defense councils for copies of all bulletins. They can also be purchased from the Government Printing Office, Washington, D.C. Each local community must assume responsibility for carrying out plans for the care of civilians, the speakers pointed out, and there will necessarily be some variation according to facilities in each locality.

Public health nurses can offer a particular contribution by visiting, on the day following an incident, the homes of those who are injured but not hospitalized. Plans should also be made for care of convalescent patients evacuated from hospitals to homes, if the hospital beds are needed for severely injured persons. Public health nurses are in a strategic position to interpret defense plans to the people in the course of their daily work, and to prepare the public for possible emergencies by giving them accurate information on what to do in case of an air raid or other disaster. Nurses need to take first-aid courses in order to learn and teach what not to do, as well as what to do, in case of severe injuries. They can give valuable help by teaching first-aid classes and home-nursing classes and by learning to make use of volunteers for service in their own agencies.

The progress made by the Red Cross in preparing Volunteer Nurse's Aides for service both in hospitals and public health nursing agencies was described by Mrs. Walter Lippmann, national director for nurse's aides of the American Red Cross. Nurses must maintain supervision of this work and they are urged to help in promoting the program. There is already a shortage of nurses in some hospitals, and nurse's aides are giving valuable help. Many more are needed if we are to be prepared to meet local emergencies.

The problem of recruitment of nurses was explored from every angle in a dis-

cussion led by Katharine Faville, chairman of the Committee on Recruitment of Student Nurses of the Nursing Council on National Defense. It is estimated that 55,000 new students—10,000 additional students besides those who entered schools of nursing in 1941-1942—should begin their nursing education in 1942, in order to meet the country's future needs for nurses. The expansion of existing facilities in schools of nursing was discussed by Isabel Stewart, chairman of the Committee on Educational Policies and Resources of the Council.

The use of the \$1,200,000 appropriation by Congress for nursing education was reported by Pearl McIver, senior nursing consultant, United States Public Health Service. Approximately 3000 graduate nurses have been enrolled for refresher courses and about the same number of undergraduate students have entered schools of nursing through federal aid. In addition, about \$210,000 has been expended for postgraduate education, including public health nursing. A deficiency appropriation of \$600,000 has been passed to extend still further the education of nurses. (See page 285.)

Plans to develop a Student Reserve of the Red Cross Nursing Service—for all students in the last half of their senior year in schools of nursing which meet requirements, as a step toward securing nurses for military service—were outlined by Gertrude Banfield, assistant director of nursing service, American Red Cross.

Various types of auxiliary nursing service which are being used to supplement professional nursing service were discussed under the leadership of Edith Smith, assistant executive secretary of the Subcommittee on Nursing. A progress report on the National Survey of Registered Nurses was made by Marian G. Randall, chairman of the Special Committee on Nursing Inventory. State nursing councils were urged to plan to

*(Continued on page 243)*

# Vincent's Infection of the Mouth

By HARRY LYONS, D.D.S.

This disease, which has long been associated with warfare, assumes importance as a condition which may become a health problem under present conditions

**P**OPULAR information concerning Vincent's infection of the mouth first appeared during World War I. The large number of cases which prevailed among the troops engaged in trench warfare led to its designation as "trench mouth." This term continues to be used as the popular synonym for Vincent's infection of the mouth.

The earliest detailed descriptions of this disease did not appear in the literature until the last decade of the nineteenth century. However, the disease probably antedates by many centuries the era of Vincent, after whom the disease is named. Its association with military strife is not limited to modern warfare. The literature contains many references to armies plagued by sore, ulcerated, and foul-smelling mouths. From the recorded symptoms, paralleling those of the disease as known today, it may be stated with reasonable certainty that man has suffered from this disease since the early days of recorded history.

The occurrence of Vincent's infection of the mouth is not limited to any age group. The acute type occurs more often in children, adolescents, and young adults. The chronic type is more often seen in older adults, usually as a complication of other diseases of the structures surrounding and supporting the teeth. Strangely enough, this disease does not occur in mouths before teeth erupt or after all teeth have been

lost. The explanation of this phenomenon is that a so-called incubation zone, free of oxygen, is necessary as a harbor in which the causative bacteria may lodge and thrive. Such a zone in the mouth is supplied by the unattached portion of the gums in their relation to the teeth. This anatomic relationship often affords rather deep incubation harbors, especially around partially erupted wisdom teeth. As a consequence, Vincent's infections frequently develop during periods of tooth eruption in adolescents and also in teething infants.

The incidence of this disease is believed by some observers to be markedly increasing, especially among adolescents and young adults. A similar unproved assertion is made in reference to the occurrence of the disease in women.

## CAUSES AND PREDISPOSING FACTORS

The exact identity of the causative bacteria was not established until very recently. It is now believed that four different micro-organisms working together are responsible for the bacterial phase of the disease. These particular bacteria grow only in an environment free of oxygen. This accounts for many important aspects of the course which the disease follows.

Small numbers of the bacteria associated with Vincent's infection of the mouth may be found in most mouths during health. They probably may be regarded as normal inhabitants of the mouth along with the many other

varieties routinely observed. This indicates that certain factors predisposing to the infection are probably of much greater importance than the presence in the mouth of small numbers of these bacteria. Axiomatically, the mere presence of bacteria in the mouth does not in itself constitute infection.

The factors predisposing to Vincent's infection of the mouth are numerous and varied. Some of these factors are local or oral conditions; others are systemic in nature.

The systemic predisposing factors may include:

1. Vitamin deficiencies.
2. Diseases of the blood and blood-forming organs.
3. Allergies.
4. Dietary and drink indiscretions.
5. Certain febrile and debilitating diseases.
6. Effects of certain drugs.

The predisposing factors acting locally in the mouth include all the various irritants arising from causes such as malhygiene and defective teeth. Great emphasis is placed on the probable relationship of tobacco smoking to Vincent's infection of the mouth. Many clinicians believe that the increasing incidence of this disease claimed to be prevailing among women and adolescents of both sexes, and the increase in the smoking habit are related. The effects of smoking undoubtedly vary widely with the susceptibility or tolerance of individuals. However, clinical observations indicate an important relationship. The chemical irritation of the mouth tissues, with its effects on circulation; the lowered hygiene; and the displacement of the normal oxygen-containing air from the mouth—all these favor the overgrowth of the causative bacteria and enhance their ability to invade the tissues. Clinical confirmation of this relationship may be found in the increased efficiency of treatment when abstinence from smoking is required, and the failure of patients to respond

to treatment when the habit is continued. In the latter instance, results of treatment are often unsatisfactory and recurrences are frequent.

#### SYMPTOMS VARY

The symptoms of Vincent's infection of the mouth vary widely with the intensity of the disease. The acute form is characterized by marked local discomfort, a foul characteristic odor, inflammation, ulceration and bleeding of the gums, excessive salivary function, enlarged glands of the neck and general malaise. These symptoms decrease in intensity as the disease subsides to chronicity. In its chronic stage, the disease presents a slow, ulcerative process which gradually destroys the gums and other structures that support the teeth. The gums bleed readily but other symptoms may be so mild as to escape notice by the patient.

#### TREATMENT OF THE DISEASE

The local treatment of Vincent's infection of the mouth is distinctly a dental problem. However, medical consultation is sometimes advisable or necessary to care for the systemic conditions which may contribute to or result from the oral infection. Certain manipulative measures designed to improve local hygiene, to remove various irritants, and to open, cleanse, and irrigate the focal incubation zones constitute the *sine qua non* of local treatment. Abstinence from smoking should be required. The value of drugs topically applied is open to question. Numerous drugs have been advocated for use, both topically and by injection, in the treatment of this disease. However, findings of scientific tests to establish their real virtues have yet to be presented. This is true not only of drugs for chair-side use by the dentist but also of the innumerable mouth washes which have been proposed. A warm saline solution will serve all the useful purposes of

a mouth wash, whereas the cumulative effects of some drugs used in mouth washes may be injurious. This is particularly true of sodium perborate. The indiscriminate and prolonged use of this and other drugs may result in marked chemical injury to the tissues of the mouth.

#### IS THE DISEASE COMMUNICABLE?

Considerable debate still prevails among authorities regarding the possibility of contagious transmission of Vincent's infection of the mouth. The large numbers of cases which have been reported at various times are cited as evidence of its communicability. However, the occurrence of large numbers of cases in an army or institution may

just as readily be due to other factors, such as the debilitating conditions under which these individuals live, or a general dietary deficiency. Under such conditions, an outbreak of the disease cannot properly be called an epidemic. In fact, the contagious transmission of this disease in man has never been scientifically demonstrated. However, patients suffering from Vincent's infection of the mouth, particularly the acute form, should be advised to exercise the simple hygienic precautions usually practiced in other instances of acute oral or respiratory disease.

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This article is contributed by the Dental Health Education Committee of the American Dental Association.

#### Nursing in War

*(Continued from page 240)*

keep inventory information up to date for use in each locality.

"What can we do in our state?" was the recurring question. Many urgent things are to be done and the help of all nurses must be enlisted. Activities must be divided and carefully assigned to those best qualified to do them.

Recruiting is one important duty. Speakers should reach every high school, college, and university, to show students the opportunities to be found in the nursing profession. Scholarships must be secured so that no well qualified applicant is prevented from becoming a student nurse by lack of funds.

Good working relationships between nursing councils and defense councils should be developed in order that nurses may play their full part in civilian defense. Money must be found for the work of the state nursing councils. Local nursing councils must be formed to study the nursing needs of each community; to keep an accurate, current account of nursing resources in order to

assure that 10,000 more nurses are secured before July 1 for military service; and to make sure that essential community nursing services for the care of the civilian population are maintained, while preparation is made for any possible emergency.

Advice should be made available to the individual nurse who needs help in deciding where her own service can best be given. Inactive nurses must be sought out and prepared for return to active service. Auxiliary nursing services must be effectively used. Volunteers must be taught and utilized. The public should be kept informed in regard to the need and supply of nurses, and should be brought in on community planning.

These things must all be done and done quickly. This is the greatest test nursing has ever undergone. No obstacles must be allowed to slow up accomplishment. The situation does present serious difficulties, but they are not insurmountable. Tremendous opportunities are offered for new accomplishments in nursing.

R. H.



## Incubators for the Premature Baby

WORKING drawings and specifications for three types of incubators for premature infants have been prepared by the National Youth Administration in coöperation with the United States Children's Bureau. These incubators may be produced by the NYA for co-sponsoring state, county, or city health departments or publicly owned hospitals. The agency for which the incubators are made will be required to bear the expense of the materials, crating, and shipping—if shipping is necessary. The estimated cost of crating is one dollar per incubator, and the shipping weight of each of the three models will be under 15 pounds.

The following types of incubators are available, according to a release from the NYA, and should be referred to by model numbers:

### *Model No. 1*

An electrically heated incubator, the design for which is a modification of that used by the Massachusetts State Department of Public Health. This incubator

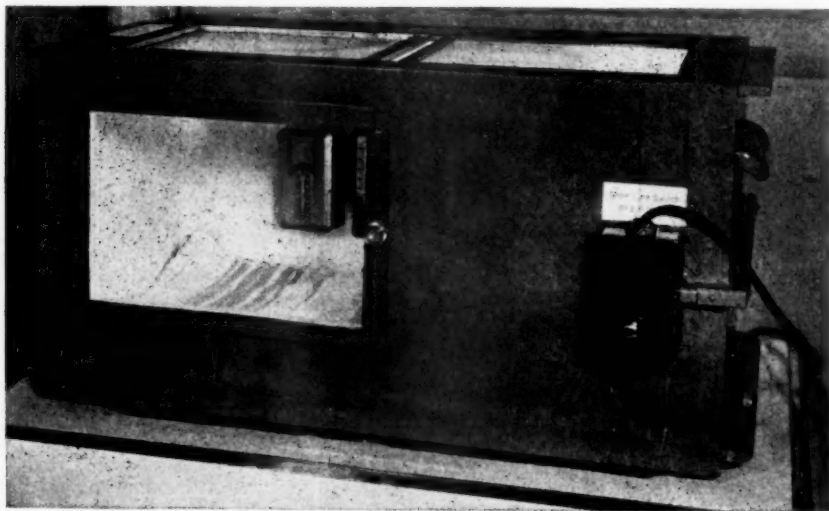
is adapted for home or hospital use. It can be set up on a table with the wooden bottom in place, or the bottom can be removed and the incubator placed directly on a mattress in a crib. The estimated cost of materials is \$17.26, subject to revision due to market changes in cost of materials.

### *Model No. 2*

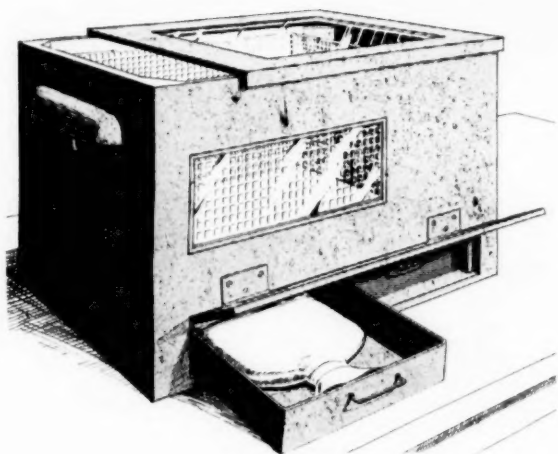
An incubator to be heated by means of heated bricks, sand, or water (in bottles) placed in pans on the floor of the incubator in the space under the basket containing the infant. This incubator is for home use. It can be set up on a table at a convenient height. The estimated cost of materials is \$5.95, subject to revision due to market changes in cost of materials.

### *Model No. 3*

A hand carrier or ambulance incubator heated by hot-water bags or bottles placed on the floor of the carrier under the cradle. This incubator is designed to keep the infant warm during transportation from home to hospital or



Model No. 1 can be used in home or hospital



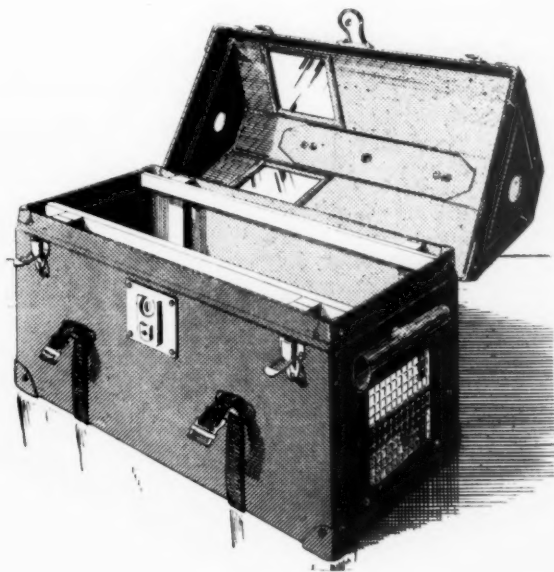
Model No. 2 can be set up on a table of convenient height for use in the home

from delivery room to nursery. The estimated cost of materials is \$4.53, subject to revision due to market changes in cost of materials.

Blueprints for these incubators have been transmitted to each state youth administrator. A limited number of ad-

ditional sets of the blueprints are available upon request, from the National Office, Division of Work Projects, National Youth Administration, Washington, D.C.

Pictures are by courtesy of the Children's Bureau, U. S. Department of Labor.



Model No. 3 is a carrier which is intended for transportation of the baby

# New Sources of Nurse Power

By ELIZABETH G. FOX, R.N.

Suggestions for the use of inactive nurses and non-professional workers to supplement the service of depleted staffs are made by two N.O.P.H.N. subcommittees

**T**ODAY public health nursing agencies, both official and non-official, are already experiencing difficulty in maintaining full staffs of nurses. This is partly because the United States Public Health Service is drawing upon some of our staffs for urgent defense work, and the American Red Cross is taking nurses from others for its consultant service. This is as it should be, and we should meet such depletions cheerfully. Perhaps a larger factor in the shortage is the gradual drying up of our usual source of new nurses for our staffs—the young graduates. Many who in normal times would be coming into public health nursing are now responding to the needs of the Army and Navy. This, too, is as it should be, and we cannot deplore it, even though our public health nursing ranks are becoming steadily thinner.

At the same time, public health nursing agencies are faced with responsibilities, heavier than they have ever known before, for protection of the health and morale of the civilian population—especially the workers in war-production industries—and for preparation to give emergency service in the event of enemy action on our own soil.

It is not surprising, therefore, that we are all wondering what we can do to make up for this steady depletion of our forces, and are looking about for new possibilities of assistance in this emergency. Two sources seem to offer help: first, inactive nurses may be drawn back

into service; second, lay women—among whom there is a strong upsurging of interest and desire to help—are increasingly willing to come to our assistance as volunteers.

Obviously, neither of these groups of potential helpers can be put to work at once without preparation for the duties they are to perform. We all realize this and we are turning to the National Organization for Public Health Nursing for guidance, as is evidenced by the many letters received by the National from worried nurses seeking advice.

Recognizing the growing urgency of the need, the N.O.P.H.N. appointed two subcommittees of the Education Committee to consider these problems—one to study ways of giving the inactive nurse a brushing up and some understanding of public health nursing; the other to study the possible functions of the nonprofessional volunteer and the kind and amount of instruction needed to equip her for useful service. The results of these deliberations are set forth and amplified in this article.

## THE INACTIVE NURSE

Unquestionably, we can make good use of many nurses who are out of practice, but who want to get back into uniform and do their part in this war. Inactive nurses who wish to be used in public health nursing services fall into several groups. Some have been public health nurses in the past and others have never done any public health nursing.

Some have had broad experience as public health nurses, but it may have been a number of years ago. Others were with us only a short time before getting married, but their service may have been quite recent. Some who have had no public health nursing experience have served many years in other fields of nursing. Others married soon after graduation, years ago, and have not been in active service since. Obviously, these nurses need very different kinds of preparation before they can be productively used in public health nursing. If a university refresher course in public health nursing does not seem to be the solution—as we think it is not—what then is the answer?

First, it seems clear that every nurse who has not been active in any nursing field for the past ten years—whether she is a former public health nurse or not—needs to return to the hospital for a basic refresher course. Medicine and therapy have made such progress in the past decade that the nurse who has not been in close touch with these changes will be at a great disadvantage and will have difficulty in understanding the newer treatments and procedures. A hospital refresher course preceding appointment should, in the judgment of the committee, be a requirement for all candidates who have been inactive for ten years or more. For those who have left active practice more recently, some review of recent changes in content and emphases through directed reference reading would be helpful.

But this general preparation is not sufficient. The next step should be an introduction to the work of the agency in which the nurse is to serve. Public health nursing agencies have customarily arranged an introductory period for new staff nurses, consisting of two months or more of instruction and demonstration, and accompanied by closely supervised practice adapted to the agency's service and the needs of the individual nurse. This has been valuable in all agencies,

but indispensable for those organizations which have not been able in the past to require postgraduate preparation in public health nursing before appointment of nurses to their staffs.

An introductory period designed along these familiar lines and given, in terms of the agency program, by the organization which is employing the nurse, would in the committee's opinion serve the same purpose now for the ex-nurse that it has done in peacetime for the new nurses on our staffs. Some adaptation to the needs of the individual nurse in relation to her preparation and experience—how much, what kind, and how recent—is of course important.

This, then, is the answer the committee offers to the problem of incorporating the ex-nurse into our public health nursing staffs. "What will this do to our standards?" some readers will ask in alarm. And it is a question very much to the point.

The committee recommends that permanent positions be given only to those nurses who meet the usual requirements of the agency. If it is necessary to employ nurses who do not meet these requirements, the committee advocates setting up a special classification which would give them the status of a temporary appointment for the emergency period only. Especially important is a clear understanding with each nurse, before employment, as to her status, although care should be taken that she is not made to feel she is not valuable.

In addition to employment of nurses to replace staff members who have left, the committee believes that everything possible should be done to secure the volunteer services of professionally trained people, such as former nurses, nutritionists, teachers, and other workers. The kind and extent of preparation and orientation which such volunteers should have will of course depend on their background and on the specific service they are to give.

#### NONPROFESSIONAL WORKERS

The use of nonprofessional volunteers is not new in public health nursing, but it has not as yet become universal practice in spite of its demonstrated value. Now, however, many agencies are considering seriously the possibilities of using volunteers, both because of the pressure of work and because women are offering to help. Volunteer bureaus are stimulating interest among people in general, while volunteers are seeking opportunities for service outside, as well as inside, of hospitals. Volunteers are used not to replace paid workers, either professional or nonprofessional, but to supplement the existing staff so that needed community services can be carried on.

To avoid confusion, the term "Volunteer Nurse's Aide" is used by the N.O.P.H.N. for the worker who has completed the American Red Cross course for these aides, and the term "volunteer assistant in public health nursing" for the worker who has not completed this course.

Agencies which have not used volunteers extensively are asking what responsibilities can safely and profitably be given to volunteer assistants in public health nursing. Some organizations hesitate to undertake any project that may involve them in a burdensome program of instruction and supervision.

Experience has shown that careful planning for the recruitment, selection, placement, training, and supervision of volunteers who are to perform duties of a nonprofessional nature is essential if their assistance is to be of real value. Principles related to these essentials of a volunteer program and specific suggestions for their application are found in materials\* published by the N.O.P.H.N.

\*National Organization for Public Health Nursing. Board Members' Manual. The Macmillan Company, New York, revised 1937.

Davis, Evelyn K. The Volunteer in Public Health Nursing. National Organization for Public Health Nursing, 1790 Broadway, New York, 1941.

Agencies have learned the importance of adherence to these principles in peacetime, and they are especially important in wartime when we are confronted with emergency situations. Great care should be exercised in the use of volunteers who are to assist with duties of a professional nature, and necessary precautions must be taken to assure safe care for the patient and family. The committee which considered the question of the preparation and use of nonprofessional volunteer assistants came to several definite conclusions which are quoted here in full:

#### VOLUNTEER FUNCTIONS APPROVED

The Committee approves the following functions\*\* for lay volunteers:

1. Nonprofessional duties in the office and at child health conferences, clinics, and mothers' classes.

a. Clerical jobs of all kinds, such as answering the telephone, filing, recording, keeping the nurses' time book, sending postcard notices, typing material, ordering supplies, stocking the nurses' bags, making aprons, and mending.

b. Acting as hostess at child health conferences, clinics, and mothers' classes, getting out records, keeping reports, sending mothers in turn to the doctor, keeping the appointment book, weighing and measuring, and getting out, checking, and putting away supplies.

c. Assisting with publicity.

d. Transporting patients and also taking nurses to their districts.

2. Nonprofessional duties in the home—making home visits.

a. Inviting mothers to clinics or classes, or finding out whether children have been immunized.

b. Carrying a message from the nurse, or going on other errands to the homes of patients.

c. Staying with children while the mother goes to the doctor's office or clinic.

d. Doing simple diversional therapy.

The committee agrees that in order to perform the functions listed in these two sections, the only training the volunteer needs is an orientation course, with instruction in the particular tasks to be

\*\*This list is intended to be suggestive rather than exhaustive.



assigned her, both of which should be given by the agency with which she is to work. It is not necessary for her to have taken the Red Cross Volunteer Nurse's Aide course or the Red Cross Home Nursing course.

The orientation course in the agency should be given to all volunteers who are to contribute service. It need not be a long or formal course, but it should give the volunteer some idea of the work of the agency; some knowledge of professional ethics; some understanding of the agency's conception of its responsibility to its patients and of its relationship to the community welfare program as a whole; and some idea of community resources.

3. Nursing care in the home—visiting in the home to assist the nurse.

- a. Helping her turn, lift, or care for a heavy or helpless patient.
- b. Helping her with postpartum care and care of the newborn infant.
- c. Helping her with the care of several patients in the same family, as during an epidemic.

The committee thinks that the volunteer might be left to give the bath by herself to patients with some degree of disability who are unable to care for themselves though they are not ill, if the nurse has satisfied herself as to the patient's condition. It is agreed, however, that the volunteer should not be used to do what is ordinarily done by the family unless for some reason the family needs such relief. In other words, family independence must not be broken down. The committee approves the functions listed in this third group on an experimental basis.

The committee agrees that in order to perform the duties in section three, the volunteer should have had the Red Cross Volunteer Nurse's Aide course or the Red Cross course in Home Nursing, preferably the former. She will also need the orientation course, instruction, and supervision in the particular tasks she is to perform in the agency as

described above. In a great emergency, the agency which is unable to recruit either Volunteer Nurse's Aides or women who have had the course in Home Nursing will itself have to prepare the volunteers for assisting with nursing duties.

#### PRINCIPLES DEFINED

The committee also agrees on the following principles with regard to the use of nonprofessional volunteer assistants:

1. That there is a valuable contribution to be made by nonprofessional volunteers. The past experience of public health nursing agencies confirms this belief and gives solid ground for present plans.

2. That all public health nursing agencies, whether official or nonofficial, urban or rural, may well give serious thought in these times to the building up of a volunteer service, if they have not already done so. The committee believes it is the agency's duty to do this.

3. That the agency should start using volunteers for non-nursing duties such as are listed in the first two sections, and in this way get experience in working with volunteers.

4. That the further step of using volunteers to assist directly with nursing duties may then be taken by the agency. The patients and their families will have to be educated to understand and accept this volunteer care.

5. That in the presence of an extreme shortage of nurses, it may be necessary to give even more responsibility for nursing procedures to volunteers, but this should be a last resort.

If a group of volunteers is given opportunity to learn the work of the agency and to assist nurses in the home, certain selected nursing activities can be turned over to them without too much danger, in case of great emergency.

#### THREE KINDS OF VOLUNTEER WORK

The work which volunteers may be called upon to do will fall into the three general categories described above. There

is ample precedent for all the items listed in the first category. Experience has amply proved that volunteers can do these things well, and in doing them can save the nurse's time for professional duties. The items under the second category have had less trial, and the value of using volunteers for these activities is as yet unproved. The idea is to save the nurse unnecessary visits, but it is realized that the purpose of a nurse's visit is seldom so limited. Moreover, there are often other factors in the situation which need attention and which are beyond the province of the volunteer. However, the accomplishment of even a limited purpose by the volunteer might be better than no visit at all.

The third category of tasks breaks new ground, and the results are less predictable. The committee suggests, therefore, that the local agency proceed slowly and experimentally with a small number of Volunteer Nurse's Aides until it has demonstrated the practicability of this step and has learned how to proceed successfully on a larger scale. The pressure of events may of course force us to go ahead before we have had a chance to try these volunteer activities experimentally—which is one good reason for making an early start in using lay people for nonprofessional duties.

Not only does the committee consider training as a Volunteer Nurse's Aide unnecessary for satisfactory performance of the functions in the first two categories, but it believes that such training

should not be encouraged for volunteers whose work is to be limited to these activities. The training of Volunteer Nurse's Aides is placing a heavy burden on hospitals at a time when they are trying to carry on their work with depleted staffs. Also, this training is primarily directed toward auxiliary nursing service in hospitals and there will probably not be enough Volunteer Nurse's Aides to meet all emergency needs there, leaving still less chance for their use in the public health nursing field. In the light of these facts, we should not demand training where it is not needed. Then, too, there are many capable women—willing and able to help us with non-nursing duties—who are not in a position to take the Volunteer Nurse's Aide course, and whose help can be used to excellent advantage.

Today, the contribution of every person counts and must be used where it will be most effective. Public health nursing agencies are already drawing upon supplementary sources of help to carry on their essential programs for the protection of the health of the civilian population. Two possible sources of assistance are the inactive nurse who wishes to work in a public health nursing agency, and the nonprofessional volunteer assistant. It is hoped that the suggestions of the N.O.P.H.N. subcommittees for the preparation and use of these workers will be of value to agencies charting a new course to meet the needs of this emergency.

**T**HE MERIT System Committee of the American Public Health Association is experimenting with certain possible types of items for future use in examinations for public health nursing positions. The Committee will have room 788 at the Palmer House during the Biennial Convention and would appreciate having as many public health nurses as possible take these tests in order that some preliminary information may be obtained regarding the usefulness of certain types of items. Nurses may take the tests anonymously and will be given their scores, but no interpretations can be attached to the scores.

## One- and Two-Visit Cases

By JEAN GREER ROBERTS, R.N.

**T**HE MAIN OBJECTIVE of most public health nursing organizations in the beginning was to make visits. They were eager to reach as many people as possible with their particular kind of service. This seems logical, since it was necessary for agencies to become well known if the advantages of care and the ever-increasing information about health were to be made available.

After a time certain groups began to wonder about these calls. Questions arose. Were the people who needed care most being reached? What kind of service was being given? And most important of all, perhaps, what was the teaching value of these visits? And so, over a period of years, studies have been made covering many angles of public health work.

In services primarily organized to give morbidity care, one of the items which came under close scrutiny was the short-term case. There has been much discussion about the one- and two-visit case—its possibilities versus its liabilities—particularly as the percentage of this type of case increased. Let us consider briefly both sides of this question. First, what are its undesirable features?

One of the aims of a morbidity service is to reach the acutely ill in need of service. A high percentage of short calls might indicate that patients with minor illness are being seen rather than those with serious illness who most need care.

In giving bedside care and supervision, the nurse has excellent opportunities for teaching. Effective teaching depends somewhat on close contact with a family over a period of time long enough to uncover its needs and assist the family in planning to meet them. Therefore, a number of consecutive visits would

afford greater possibilities for teaching.

The one-visit calls include a number of "not at home" calls, "wrong address" calls, and trivial complaints which take up the time of the nurse but give opportunity for little or no actual nursing service. Sometimes a contact in which the nurse is unable to demonstrate the possibilities of the service offered may bring an unfavorable reaction and result in failure to call the nurse when a definite need is present. On the other hand, records often show this group of calls to contain a number of frequent repeaters—families who call for service at short intervals, often for the same condition. Although the nurse counts success partially in terms of being called back into the home, should she not scrutinize the reason for return calls in the light of previous contacts with the family? If our teaching is effective, should not our families become less dependent?

What about the desirable features of one- and two-visit cases? As the nurse gains experience in working with people, her skill in winning their confidence and discovering their needs grows. Therefore, it is conceivable that even a short contact could prove helpful and effective. Furthermore, will not the single call serve as a case-finder for more serious needs? Even a visit which may not in itself be particularly significant affords opportunity to become acquainted with the family and explain the facilities available for care when needed.

Another consideration is the possibility of preventing a prolonged illness by prompt action. Serious conditions may start with mild symptoms, and early medical care may abort many illnesses in the early stages. Families are there-

fore encouraged to call for service early in illness—which undoubtedly results in a certain number of one-visit calls.

Sometimes there is a specific need which one call is sufficient to meet. Prolonging a case over a number of visits, when one well conducted call is sufficient does not indicate wise case management. With further scientific discoveries, more effective health education, and better quality and distribution of facilities for medical and nursing care, can we not expect a change in the type of cases needing care and in the length of illness?

It has been said that continuity of contact is important to effective teaching. However, if the needs and service rendered are carefully recorded, perhaps in certain instances a series of single visits over a period of time might be as effective as those made in closer succession.

Recently, in an endeavor to collect some specific information, the nurses of the Metropolitan Life Insurance Company on the Pacific Coast took part in a two-months' study of short-term cases. The plan was discussed with one of the larger staffs, and after their suggestions were obtained, letters were written to the rest of the group. About seventy nurses participated. The plan was as follows. At the conclusion of the visit, the nurse would attempt to evaluate the effect of her visit and note this observation on the record.

A study of these records at the conclusion of the period yielded the following information: Of 1830 one-visit cases, 427 or 23 percent showed no evidence of a definite problem; 635 or 35 percent showed an opportunity for instruction with interested response from the family; 594 or 32 percent gave indication that definite problems existed; and 174 or 10 percent were "not found" or "no policy" cases.

In the 594 cases in which a definite

problem existed, the service fell into the following general categories:

1. Family referred for medical care	193
2. Information given regarding other agencies	70
3. Interpretation of physician's orders—no further care needed	62
4. Assistance with problems of child care having immediate bearing on child's welfare	14
5. Assistance with problems of mental health	12
6. Suggestions on nutrition and general health habits	124
7. Consultation with other members of family on further care	5
8. Suggestions regarding immunizations	114

Total 594

Of course the number of case records reviewed in this study was small, and evaluation of the visits by the nurses themselves may not always be objective. Nevertheless, it is interesting to note that the staff nurse who was in direct contact with the situation thought that 35 percent of these cases afforded opportunity for reasonably effective teaching and 32 percent, for assistance with definite problems.

Certain conclusions may be reached. It is reasonable to expect, even with intelligent planning, that every organization will have a certain number of so-called unproductive calls, wrong addresses, not-at-home visits, trivial complaints, and the like. Could more effort be directed to reducing this figure to its irreducible minimum? And could more study be directed to the type and content of these visits? Are they meeting a definite need? If the individual staff nurse is given time and encouraged to study her own case load in the light of the objectives of her organization, she will be more interested in improving each individual visit. In times when the demands on public health nursing are increasing, the importance of thoughtful planning and the need for making every visit count should be evident to every public health nurse.

# In Memoriam

*They shall grow not old, as we that are  
left grow old:  
Age shall not weary them, nor the years  
condemn.  
At the going down of the sun and in the  
morning  
We will remember them.*

From *For the Fallen* by Laurence Binyon

In May each year we list those public health nurses who have died during the past year, and we ask our readers to send us word when any of our co-workers have passed away.

Bertha Beers, November 8. New York State Department of Health, Albany, New York.

Mrs. Grace C. Briggs. Buffalo, New York.  
Helen Bigney, May 4. Estherville, Iowa.

Mrs. Amelia Clifford, October. Supervisor of nurses, Bayonne Visiting Nurse Association, New Jersey.

Kathryn Cosgrove, October 22. School nurse, Harrisburg, Pennsylvania.

Mrs. Leone Bell Cypert, January 1, 1942. City health nurse, Russellville, Arkansas.

Eveana R. Dailey, December 29. Philadelphia, Pennsylvania.

Anne C. de Rivers, November 25. Philadelphia, Pennsylvania.

Louise C. Dierson, September 4. St. Louis, Missouri.

Mrs. Eleanor Ericson, March 27, 1941. Mrs. Ericson was on the staff of the Chicago Visiting Nurse Association for 14 years. Kentland, Indiana.

May G. Graham, May 15. For 16 years industrial nurse in Bloomfield, New Jersey. She was among the first public health nurses to be employed by the Society of New England Women of Montclair, New Jersey. New York, N.Y.

Mrs. Mabel E. Haley, staff nurse, Los Angeles City Department of Health, Los Angeles, California.

Mrs. Meta W. Hansen. City school nurse, Fresno, California. Killed in an automobile accident.

Mrs. Nell H. Johnson, July 2. Mrs. Johnson was a member of the staff of the Floyd County Board of Health for seven years preceding her retirement two years ago and was twice president of the Georgia State Organiza-

tion for Public Health Nursing. Rome, Georgia.

Julia C. Kelly, July 2. Phoenix, Arizona.

Anneke Kolleywyn. Montezuma County Nursing Service, Cortez, Colorado.

Mrs. Clara McDonald, February 6, 1942. New Orleans, Louisiana.

Lauchlin K. MacInnes, June 28. Boothbay, Maine.

Mrs. Lois Owen, February 22. School nursing adviser, Pennsylvania Department of Public Instruction. Philadelphia, Pennsylvania.

Mrs. Mildred C. Peebles, October 15. Nashville, Tennessee.

Edna D. Porter, December 13. School nurse, Concord, California.

Mrs. Irene Reed Snowden, April 3, 1941. Mrs. Snowden was a public health nurse for many years before her marriage. Philadelphia, Pennsylvania.

Miriam Sprague, December 16. Pittsfield, Massachusetts.

Louisa Spring, February 1942. Portland, Maine.

Adeline Stoner, February 19, 1942. School nurse, Roosevelt School, Union City, N.J., during the past 15 years. North Bergen, N.J.

Alice Mae Thompson, May 19. Rock Island, Illinois. Member of Fifth District, Illinois State Nurses Association.

Mrs. Jennie S. Tracy, December 27. Harrison, New York.

Mary W. Tucker, March 4. Little Rock, Arkansas.

Nancy Vance, February 18, 1942. State Department of Health, Richmond, Virginia.

Mrs. Freda Whyte, public health nurse, California State Department of Public Health, San Francisco, California.

Mary B. Willeford, December 24. Public health nursing consultant, Children's Bureau, U. S. Department of Labor, Washington, D.C. Formerly district nurse-midwife of the Frontier Nursing Service.

Mrs. L. C. Yenglin, Mission, South Dakota.



# Staff News Letter Tells Story of Work

By THERESE KERZE, R.N.

This house organ of a small staff is a medium for interpreting the work to board, contributors, and other agencies

OUR STAFF News Letter was born in the fall of 1938 as a monthly information bulletin. The idea is not an original one, for many commercial concerns have a company leaflet. Among nursing and health agencies, however, house organs seem to be published chiefly by large staffs. Ours is a small staff, and therefore our experience may be of interest to other small staffs throughout the country.

The first issue of the Judson Health Center News Letter consisted of a single page, typewritten on both sides. The staff supplied the literary material, which was arranged by the administrator. Twenty-five copies were made. Now the bulletin has grown to a two-page leaflet mimeographed on both sides, and 200 copies of each issue are made. The mimeographing is done by the staff with the assistance of National Youth Administration students and volunteers. Without figuring the cost of labor, the expenditure comes to about \$2.90 an issue, including \$1.60 for envelopes and stamps. The format has been improved and sketches on the cover introduced.

After the preliminary issues, a member of the staff was appointed editor-in-chief, with the supervisory staff members serving as associate editors. Editors and staff are all amateurs with no previous journalistic experience.

The mailing list has shown the same growth. At first only the staff and medical men comprised the list. Then more and more names were added, including members of the Board of Directors.

Instead of automatically placing all other local agencies on the list, we included them only after individual contacts were made. Many agencies have requested copies, stating that they had seen the bulletin or heard about it. Now the list includes other organizations—nursing, health, and recreational agencies, hospitals and clinics, schools, churches, a local newspaper, and libraries—many in the nearby areas and others farther away; former staff workers now with other organizations; and physicians and dentists. Sending the News Letter to contributors has proved helpful in keeping them informed—and judging from their comments they do find it informative.

The picture on the cover page usually leads into the editorial on the other side, written by one of the supervisors. Examples are as follows:

Picture: A stork in flight carrying a baby

Caption: Judson Health Center Maternity Program, by the supervisor of nursing

Picture—A farmer at work

Caption: Helping the Farmer

Editorial: Food Demonstrations Using Surplus Food Commodities, by the supervisor of nutrition

Picture: Youthful young lady

Caption: NYA

Editorial: The National Youth Administration Workers at Judson, by the assistant director

Picture: An owl

Caption: Be Wise, Consult Your Dentist

Editorial: Dental Service at Judson Health Center, by the supervisor of research

The second page contains brief articles contributed by the staff, giving a picture of our program and the people we serve. Highlights of "A Day with a Judson Nurse" were described in a joint article

by two staff nurses in one issue. Stories of activities always have a human interest value which can be woven into factual reports.

#### *Demonstrations in Clinic*

Demonstrations and discussions are now being held by the nutritionist in the Women's Health Clinic waiting room twice a week, and twice a week in the Child Health Clinics. As an experiment for one afternoon's discussion, an attempt was made to have the group suggest questions to be answered. The results were spontaneous and many questions were asked: "Is there any difference between grade A and grade B milk?" "Will a banana and milk diet for two weeks make you lose weight? How many bananas and how much milk should you take?" "Does drinking milk after eating foods with vinegar harm one?" "Is canned corn mixed with butter and milk good for a two-year-old child?" "Whenever I make iced tea several hours beforehand, it always gets cloudy. Is it the lemon that makes it like that?" "Is it safe to drink milk with tomatoes?" Because of the interest and good results obtained by using these questions as a basis for the discussion, it is planned to present more demonstrations of a similar nature.

SUPERVISOR OF NUTRITION

#### *The New Baby*

There are so many little problems that the new mother faces upon her return home from the hospital—such as the temperature of the room during the baby's bath, a method of enlarging holes in nipples, the best method of washing diapers—that the worker's visit is eagerly awaited. At the same time factors are discussed such as the importance of absolute cleanliness in relation to the infant; the danger of open safety pins and high, unguarded tables or beds; the value of regular feedings; the physiological purpose of crying; reassurance that the baby will not smother if placed face down in the crib, provided the crib is properly equipped with a hard mattress and no pillows—but will get more exercise; reasons for regular examinations by the doctor; and similar things important to the health and proper development of the baby.

The mother, too, overwhelmed by her new responsibilities, needs encouragement to keep the appointment for her postpartum examinations. Often the nurse is able to help the mother organize her daily schedule better, permitting more time for rest and relaxation which is so important at this time.

STAFF NURSE



Cover for May 1941 issue

#### *Results of Sex Education Teaching!*

Little Ronald, five years old, was waiting his turn in Child Health Clinic today. He was accompanied by his mother who is about six months pregnant. Another woman in the waiting room who was holding a beautiful baby on her lap asked Ronald if he wouldn't like to have the baby. "No!" said Ronald emphatically, "I'm getting mine later!"

STAFF NURSE

#### *Oral Hygiene Clinic*

Age is no barrier to attendance at the Oral Hygiene Clinic. On April 22, a fifteen-months-old child attended this clinic to have her six teeth cleaned of green stains. Since the child was too young to understand the teaching on the care of the mouth, the mother was shown how to clean Mary's teeth with a bit of cotton if she felt it necessary. She will return again in six months and at that time will be shown how to manage a toothbrush.

ORAL HYGIENIST

#### *Young Men's Clinic*

Boys just about to step over the threshold into manhood are shy but well mannered. They discuss calmly and with interest the ways of keeping good teeth, keen eyes, and good health, and receive the talk on acne care with gratefulness. They come from the man-to-man talk with the doctor about hygiene, very proud of being considered responsible. They tell the worker, "He's a great guy, that doctor."

STAFF NURSE

Conferences or conventions attended, professional and educational accomplishments of staff members, and activities of board members and volunteers are described. New members are welcomed and parting members given a farewell.

#### *News About the Staff*

E—H— joined us as staff nurse on June 1. She is a graduate of Fifth Avenue Hospital, and is working for her Bachelor of Science degree at New York University. Miss H— came to us from Henry Street Visiting Nurse Service.

There are eight registered professional nurses on the Judson Health Center staff. All are members of the National Organization for Public Health Nursing. A 100 percent record!

M—M—, staff nurse, resigned on June 1 to attend New York University full time and complete the rest of the requirements for her degree.

Our supervisor of research and statistics, G—N—, is still in Washington, D.C., having been borrowed by the Consumer Division of the Advisory Commission to the Council on National Defense.

#### *Board Luncheon*

On February 20, 1941, the nursing department again prepared the luncheon for 17 board members. Swiss steak, brown rice, and home-made gingerbread were the highlights of the meal. From reports it seems that nurses at Judson Health Center have a real flare for cooking. The total cost of the meal was \$6.35, or about 37 cents each. Planning, preparation,

and sampling were enjoyed by the staff.

#### *Volunteer Contributions*

Our loyal corps of volunteers has rendered us an invaluable service throughout the year, acting as clinic assistants and clerical aides, doing the sewing and mending and a hundred and one little odd jobs that help so much in making the Center run smoothly and efficiently. During the first six months of the year about 500 hours of work have been contributed by our volunteers. But their largest contribution has been their willingness, cooperation, and the interest they have taken in the work. Unfortunately for us, the number of volunteers drops off sharply during the summer. However, in the fall we are looking forward to a renewed interest on the part of these indispensable helpers, whose service is deeply appreciated.

Yes! It is difficult to get contributions from the staff, but with a little constant urging the results have been satisfactory. The value of being able to express oneself in an interesting and concise style has been pointed out to them. The satisfaction of having one's work accepted and read by others is good for one's ego. The competitive spirit that develops among staff members in having an article accepted is stimulating.

Thus we have found our News Letter a revealing document in regard to the work and staff of the Center and a worthwhile investment.

## THE AMERICAN JOURNAL OF NURSING FOR MAY

War Gas Cases.....	Alden H. Waitt
Men Nurses and the U. S. Navy.....	Daniel M. Brown, R.N.
The Public and Streamlined Nursing.....	Eva H. Erickson, R.N.
Volunteer Nurse's Aides.....	Jane Foster McConnell, R.N.
Acute Diarrhea.....	Albert V. Hardy, M.D.
Acute Diarrhea—Nursing Care.....	Johanna J. Schwarte, R.N.
The Social Security Act and the Nurse.....	Walter Kruesi
China's War-time Nursing.....	
Our Materia Medica Garden.....	Ella T. Whitten, R.N.
The Preschool Child's Nutrition.....	Marion Breckenridge
How to Organize Local Nursing Councils on Defense.....	
With Red Cross Nurses in Hawaii.....	
Interests of Nursing Candidates.....	Marie H. Anderson, R.N., and R. Louise McManus, R.N.

# Togetherness for the Health of Children

By REBA F. HARRIS

This group of teachers and nurses studied the techniques of developing successful working relationships and a pattern of work to meet the growth needs of children

"I WANT TO KNOW how we can work together," said the public health nurse who sat by the open window one day in a public health study group.

"Why," she continued, "should we as nurses be seeking always to get teachers to cooperate with us? I do not want teachers to cooperate with me—to do merely what the health department or the school physician wants them to do. This so-called cooperation means all too often, 'you stand aside while I carry out my program,' or, 'you carry out my program when I am not here.' I want to know how teachers, nurses, parents, physicians, and community can *work together* for the health of the children in our schools."

"I believe I know what you mean," replied another member of the group. "In my county, for example, we can say that almost all of the classroom teachers and school administrators are thoroughly cooperative with the health department. They seem glad to have the public health nurses visit their schools. They are usually willing to carry out any instructions given to them by the nurses or other members of the health department. And yet there are only six or eight classroom teachers and one or more principals of buildings with whom I share that *feeling of togetherness*. We seem to think together, plan together, work together, and question results together. I have often wished that we could have the same relationships with

all classroom teachers and school administrators."

"Why do we have this togetherness relationship with only a few teachers?" asked another. "I am employed by the school board, along with a physician, to devote my full time to school work. We, too, find most of the teachers passively cooperative. Are there specific techniques or step-by-step procedures through which this feeling of togetherness can be developed?"

## ANALYZE WORKING RELATIONSHIPS

Let us analyze briefly the working relationships of classroom teachers and public health nurses. We recognize readily the essential differences in the early vocational training of these two groups. The teachers—at least the majority in our public schools today—have been schooled in subject matter and how to teach these facts to well children in groups. The early training of the public health nurse, on the other hand, has been largely with sick persons, each one an individual *for* whom she must *do* something. She has had little experience with the health education aspects of her work, which require her to guide, direct, and inspire the persons, family, or community groups to *do for themselves*.

In our work with public health nurses and teachers we find that each group has certain personal blocks in attitude toward the other. "We are not at ease with school teachers," said a public health nurse. "Every time I talk to one

I find myself waiting for her to say, 'That's wrong. Sit down,' just as the teachers did when I was in high school."

Teachers say, "Public health nurses have one-track minds. All they know is school health work. Sometimes they visit homes of the school children to urge parents to get the child's defects corrected. They bring us the same health pamphlets every year. They do not seem to understand that we teachers plan ahead for our work with our group of children, and that we would appreciate knowing when to expect the nurse for her work in our schoolroom."

#### NEW METHODS OF TEACHING

These teacher-nurse and nurse-teacher attitudes have been influenced also by the so-called teaching methods. Classroom teachers, as well as public health nurses, have worked largely as individuals. Each one is constantly *telling others* what to do, how to do. Many classroom teachers are just now learning how to work *with* children. These teachers are learning that teaching is not telling, nor is it a bag of tricks or series of devices for gaining the interests of children. They are finding that children learn in accordance with the natural process of human learning, which in turn may be influenced or retarded by classroom methods that belong to the old practice of telling-teaching. These teachers are learning something about the total growth and development of children.

Many public health nurses continue to think in terms of illness, disease, and physical defects, instead of the growth and development of the whole child in relation to these conditions. Often the nurse has not been helped to question and discard her old ideas of teaching. She continues, therefore, by *telling* teachers, children, and parents. Or she offers them devices to enlist their interest in health work. Morning inspections for health habits, wall charts for recording correction of physical defects, weighing and measuring, unrelated vision testing,

and health scrapbooks and posters are looked upon only as a bag of tricks by those classroom teachers who have some understanding of the growth needs and the learning process of children.

Both teachers and nurses need to correct those mistaken ideas about each other. Each has a definite contribution to make to child growth and development. Public health nurses should be reading some of the teachers' books and periodicals, especially the more recent ones on child growth and development and the learning process. The nurse will find it helpful to sit in the classroom and watch the progressive teacher work *with* her children. Classroom teachers should read the nurses' books and periodicals. From the nurse, the classroom teacher should learn about the health conditions of the community—about the water supply, sewage and garbage disposal, and sanitation of foods and public eating places; about services not only from the health department but from other community agencies. Visiting the homes with nurses and helping or observing in the child health conferences should give teachers a better understanding of the real values of the public health nurse in the school and community.

#### PROCEDURES THAT LEAD TO SUCCESS

Are there specific techniques or procedures by which the feeling of togetherness can be developed between teachers and nurses? In seeking an answer to this question, our study group decided that each member would write two brief reports. One would show how the nurse had worked on some specific problem with the teachers or school administrators with whom she shared the feeling of togetherness. The other would indicate how she had tried to get coöperation with another teacher, but had failed. These stories were presented for group analysis to see if there were common procedures in the success efforts which might be used to evaluate the failure efforts. From the stories or case studies



presented at this conference and gathered from other nurses and teachers, we have drawn out step-by-step procedures or techniques which seem to contribute to the working together of teachers, parents, physicians, nurse, and community.

Seven procedures which appeared to be common to most of the success experiences are listed and discussed briefly here. Since this article is prepared for nurses we are placing the initial responsibility for developing togetherness upon the nurse. These procedures are equally applicable to the classroom teacher and may be applied by all groups who wish to build this relationship. In some situations the nurse took the initiative in following through all steps; in others the classroom teacher took the initiative in one or more of the steps. In all success reports the pattern of work showed a two-way application. Teachers learned from nurses and nurses learned from teachers.

#### STEPS TOWARD TOGETHERNESS

1. Analyze your own personal attitude toward teachers in general and especially toward those with whom you do not share the feeling of togetherness.

Can you analyze your attitude toward teachers in relation to points such as early experiences with teachers and differences in academic degrees? Can you discuss your attitude with teachers very frankly, and with an objective, adult sense of humor?

2. Look for the interest, or readiness, of the teacher, and build on this interest.

To find this interest, some of the following questions may serve as a useful tool to the nurse. What are her problems in relation to her own health, the health of her pupils, or her teaching environment? What does *she* think her pupils need in relation to health? What changes or improvements does she think should be made in her classroom and in the school building? Is she satisfied

with the food the children bring from home? How about the lighting, seating, and toilet facilities? Does the teacher think they should be changed or improved? Does she have suggestions as to how the nurse or health department may help? Can you analyze your working relationships with teachers to determine whether you are merely *telling* teachers or giving them devices to secure their interest in health work? Can you build on this interest even though it does not seem as important to you as something else? Looking for the teachers' health interest is different from trying to awaken or arouse her interest. It is discovering a common base upon which to begin the development of togetherness.

3. Try to gain a better understanding of the classroom teacher's work with children and help her in turn to get a broader vision of public health.

Do you make it your business to talk to the teacher about those thrilling and fascinating experiences you have outside of the school—not alone about home conditions of school children? Do you discuss community, state, and national health problems and conditions with her? Do you find out from the teacher what new books and periodicals she is reading? Do you discuss your latest magazine article or book and offer to lend it to her? Do you watch her work with children? Do you invite her to visit your health office, clinics, and child health conferences?

4. Plan together on the basis of health needs of the group of children enrolled in each school or classroom.

If there is any single step toward togetherness, it is planning together. The nurse who really wants to develop with teachers, parents, physicians, and the community that feeling of togetherness will go empty-handed to teachers and school administrators and parents with the question, "How can we plan together for the healthful living of these children at school so that each of us will

have a better understanding of the other, and thereby find our places in the total program?" Empty-handed does not imply an empty brain; and planning does not mean blindly following all suggestions. Planning together does mean that each representative concerned is willing to see the total health needs of children, willing to question and lay aside outworn devices or methods of work, willing to work out and help carry through an entirely new pattern of work, if necessary for the growth needs of children.

In many situations the nurse and the classroom teachers are inhibited in coöperative relationships because their administrators, the superintendent of schools and the health officer or school physician, have not learned to plan administrative policies together. They, too, must search for this pattern of togetherness if the health needs of the children and the community are met.

5. Confer often, after the plan of work has been agreed upon, in order to gain a better understanding of the plan and to question your own efforts as well as that of others concerned.

Where two or more groups or individuals are concerned, the development of any plan requires frequent conferences. When you and a classroom teacher have agreed upon a certain plan in regard to immunizations of children, hot school lunches, or the behavior problem of a child, do you confer often concerning the procedures agreed upon? Such conferences build toward togetherness.

6. As a representative community agency, bring to the attention of teachers and parents other community resources which may contribute to the total growth and development of school children.

Do you know all the resources of your community and state? Are you quick to inform the teacher where she can find assistance in helping the child who stutters, the child who is truant, and the

child who does not want to play with other children? What community agencies will help with the school lunch, give advice on school gardens, or study classroom lighting and ventilation facilities? Do you assist the teacher to locate reference materials when she and her class are studying some community problem? Acquainting the teacher with other community resources is another vital step in the growth toward togetherness.

7. Set up a plan for a progress report and decide upon means of evaluating results over a given period of time.

How do you know your day-by-day activities are building toward your goals or objectives? How can you evaluate your accomplishments unless you decide upon a unit of measurement? So many home visits made, so many health talks given, so many pamphlets distributed are neither signs of progress nor units for evaluating results. Our high percentage of uncorrected defects, our low nutritional status, our poorly ventilated and lighted schoolrooms, our mounting accident rate should force us to question our activities and look for new methods of evaluating our results. When teachers and public health nurses learn to question together their failures and successes, another vital step in togetherness has been reached.

#### DEMOCRACY IN ACTION

Many men in our armed forces today owe their physical fitness and mental development to the untiring efforts of public health nurses and classroom teachers. By the same token, a greater number of physical defects could be prevented or corrected in school children today if a larger number of classroom teachers and nurses worked by patterns of togetherness. This working together for the best growth and development of children in our schools means more than passive coöperation. It means real democracy in action. These step-by-

step procedures have been suggested to help nurses and classroom teachers build toward the development of this togetherness.

Today, as never before, we need to question our individual efforts, break down artificial walls between groups and professions. Many of our pre-war interest-getting devices must give way to opportunities for the practice of healthful living at school, in the home, and in the community. For example, the hours spent in making food posters, talking about foods, and feeding experimental rats for children's observation must now be devoted to providing nutritious foods for children's lunches at

school. Greater efforts must be expended to make the consumption of this food at school an educational experience to the children and teachers. In this food problem lies an opportunity for a fundamental togetherness experience for nurses, physicians, school administrators, teachers, parents, and the community.

Today, all groups and professions concerned with the health of the school child need more than ever before to think together, plan together, work together, and question results together—the stepping stones in togetherness—if the children in our schools today are to lead us out of the darkness tomorrow. That will be their task!

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**T**HE RECORDS ROOM at the Biennial Convention in Chicago—Room 796 at the Palmer House—will be open from 9:00 to 5:00 daily during the five days from May 18 to 25. No records may be taken from the room, but fifty comfortable chairs are provided for visitors to use in reviewing the records—which have been indexed according to state and post office, type of record, and various points of emphasis. State scrapbooks of records and other material from state health departments will also be available for study. These materials are made available through the work of a subcommittee appointed by the Records Committee of the National Organization for Public Health Nursing.

The review by the subcommittee of the 130 records from 24 states, covering many kinds of public health nursing service, was an interesting experience, and the amount of time and money which organizations have put into this project seems to be justified. We hope many people will visit the Records Room and find it helpful.

## American Nurse Visits English Nurseries

DEAR FRIENDS:

This letter is written with the sound of the surf of the English Channel in my ears. The tide is rushing in and as it breaks on the rocks it makes a lovely swish. It is indeed difficult to realize that the world is still topsy-turvy as I look out on this glorious view from the window of my hotel. The hotel itself is restful, with its large rooms, hot water in the tubs, and the general sense of luxury that it has possessed for so many years and finds impossible to shed even now. Nor is it difficult to visualize the holiday company dancing in this English watering resort.

I am on a tour of some of the residential war nurseries which the American Red Cross has subsidized this past year. We have had some children from these nurseries in the hospital, and our nurses have worked in others.

There are nearly 400 residential nurseries in all for children under five years of age, which are administered for the Ministry of Health by several different organizations. The eighty or more nurseries in which the American Red Cross is especially interested are the ones administered by the Women's Volunteer Services for Civil Defense and the Church of England, Inc., Society for Providing Homes for Waifs and Strays. The money used for this purpose has come in the main from our Junior Red Cross. In addition to the Red Cross subsidy, the nurseries receive the billeting allowance of about \$1.50 a week per child, set by the government. This allowance is sometimes paid by the government, but far more often by the parents of the children. The staff usually comprises one person for every four children. A state registered nurse is the matron and her assistant has

usually had nursery training. If there are 20 children in the school, the educational authorities in the local area supply a nursery school teacher. Some of the schools have only 4 or 5 children; a few have 70 or 80; but most of them are planned to accommodate about 28 or 30.

The houses in which the nurseries are situated are of all types, from huge castles and country houses to small middle-class dwellings. They are situated in what are thought to be the safest spots—if anywhere on this tiny island may be called safe!—in the so-called "reception areas." Some of them are rented, some are requisitioned, but many are offered free. Sometimes the family—or what there is left of it after it has been dispersed for various war duties—continues to live in a part of the house, often taking a marked interest in the children and helping with them—sewing and mending, running errands, ironing, or taking the children for walks on the estate.

What an opportunity this is for children from the crowded cities to have long, long holidays in the country—none of your all-too-short two weeks in peacetime summers. The matrons say that many of the children gain as much as three or four pounds the first week after they arrive, and then they settle down to a steady one half to three fourths of a pound a week. Not bad for children two to five years old, is it? It would do your heart good to see them running about in some of the red sweaters that we knit back in our own pre-war days, and in the little dresses and suits with the American Red Cross label.

In the cupboards are tins of marmalade, again having the Red Cross label, but this time with a maple leaf around

the edge and the word, "Canadian." The American Red Cross has contributed some foodstuffs as well—usually dried milk, honey, oatmeal, and a little tinned fruit.

The Ministry of Health has supplied the furniture, wooden cribs with lovely grey and blue blankets, rest "stretchers" (the English word for "crib"), and little tables and chairs. There are usually two or three dormitories, a play-room and dining room combined (this is almost always the former drawing room), and several bathrooms and "potty" rooms. These last are always separate for boys and girls even when designed for babies of two years.

The play space for the children is of course practically limitless. There are parks, meadows, paddocks, and gardens. The enclosed tennis courts are a god-send for the new arrivals who are kept in isolation for a week or two. They can see the other children, yet they cannot mix. In the main, the toy situation is adequate for play indoors, but there is a great lack of the big out-of-doors equipment and almost a dearth of pull-push toys. I am hoping to get a group of our own personnel here at the hospital interested in making simple toys out of packing boxes that are still adorning our front yard, if we can find nails enough. It is practically impossible to buy them.

The medical supervision of these children is of particular interest. Periodic inspections are made by the regional office of the Ministry of Health, and at these times the sanitary arrangements and the general health of the nursery as a whole are considered. Physical examinations are done by a local physician about every six months. The nurses weigh the children every month and the matron keeps a medical record. In most of the nurseries I have visited, diphtheria immunizations have been done, but this practice is not nearly as widespread as on the other side of the Atlantic.

I have noticed one or two other major differences. The physician is rarely consulted regarding a child's diet. This is the sole responsibility of the matron. Also, supplementary foods, such as cod-liver oil are not used as universally as in the states. This was evidently true before the war as well as now. The government has made black currant juice and rose hip syrup available for babies under one year of age, but evidently these are not taken advantage of as widely as they should be. Black currants are very plentiful in this country and they have a greater vitamin C content than any other source. Rose hips—the little apple-seed pods that remain after the rose petals have fallen—are also an excellent source.

Another tremendous difference between English and American nurseries is in the temperature of the play and sleeping rooms of these tiny tots. The matrons are perfectly satisfied to have it cold enough to make one's breath visible at all times! I came away positively shivering. But they like it that way. Only today a foster mother of excellent education and broad experience said to me when taking her four children home from a week's stay in our hospital, "You know, Miss Phillips, I am very much afraid they will have colds after having been in this heat. Don't you think I had better keep them in bed at home for a week?" And the queer thing is that I wouldn't be a bit surprised if they did get colds—only I'd blame their cold and not our heat. It depends on the point of view, I suppose.

However, all in all, I was very favorably impressed with these nurseries. Some are better than others, naturally. But surely this experience that so many children are having will have long and lasting effects.

ELISABETH C. PHILLIPS, R.N.

*American Red Cross-Harvard Field Hospital  
Unit, Salisbury, Wiltshire, England  
February 25, 1942*



## Wartime Child Labor in Agriculture

A STATEMENT of principles to govern the wartime employment of school children in agriculture has been issued by the National Child Labor Committee in response to reports from many states that there is a shortage of agricultural labor, and that consideration is being given to relaxing educational and child labor standards to permit these children to engage in emergency agricultural work:

The National Child Labor Committee is acutely aware that the United States, as well as all other liberty-loving countries, is in the midst of an unprecedented world crisis, and that all of us must use our resources to the utmost to insure that we shall be able to walk in paths of liberty in the future. In such an emergency we must be ready to reconsider from time to time, as the situation develops, the protective standards that have been built up during peacetime. We must weigh their importance in preserving the essential strength and soundness of the democracy for which we are fighting. On the other side of the balance, we must place the possible value of their relaxation as a factor in maintaining freedom in the world.

One of the requisites in preserving the essential strength and soundness of our democracy is to safeguard the health, vitality, and education of all citizens, especially those in the formative years of life.

Any proposal, therefore, which would lower existing standards relating to education and the employment of children should be examined with great care, both as to the reality and the urgency of the need for work by children and as to the degree of harm that might result to the children.

In the light of these considerations, the National Child Labor Committee proposes the following guides for the appraisal of any suggestions for relaxation of present child labor and school-attendance standards.

### *The employment of school pupils for agricultural work during school hours*

1. Every proposal for modifying school requirements in order to permit pupils to help temporarily in agricultural work should be considered strictly on the basis of facts ascertained at the time as to the alleged emergency and should be authorized only after the state farm placement service in the state concerned has certified that sufficient adult labor is not available at reasonable wages.

2. The governor, the state department of education, the state department of labor, or the farm placement service should, in every state, be responsible for initiating the discussion of any such proposal by the departments named, and any decisions and plans for employment of school pupils should be such as are approved by these departments.

3. In no case should school pupils be employed because their labor can be secured more cheaply than that of adults. If pupils are called upon to cultivate or harvest crops on a piece-rate basis they should be paid at the same rate as adults.

4. Temporary release of pupils from school for agricultural work, away from the home farm, should be limited to those 14 years of age or over, unless in case of extreme emergency. Preference should be given ordinarily to older pupils. Administratively, it may be found desirable to limit the release of children to those in specified school grades rather than on an age basis only.

5. School time lost because of temporary emergency agricultural labor should be made up.

6. Recruiting of labor of pupils in school for emergency agricultural work should be done as a community enterprise, under plans that have been approved as proposed above, and should be under educational supervision.

*Child labor standards and emergency agricultural work outside of school hours*

Regulations, where any exist, controlling the use of children in agricultural work outside of school hours, are so low throughout the country generally, that there should be no occasion for relaxing them for emergency agricultural work.

### AIDS TO INTERPRETATION

IT IS NOT always easy for public health nurses to give thought to public relations under pressure of emergency demands. Yet this is the very period when sound publicity, sound interpretation, are most valuable. It is also the time when a good public relations program can most easily be established. For the dramatic situations that war produces can be used as legitimate and colorful means of acquainting the public with an agency's regular and continuing service to its community.

The Social Work Publicity Council has practical help to offer health organizations and social and civic agencies in their efforts to interpret their programs and to gain support. The Council is a clearinghouse of information on publicity techniques and materials used by social agencies throughout the country.

Almost indispensable to any agency seeking community support is the Council's magazine *Channels*, which appears eight times a year. This is a vivid, practical digest of what is going on in public health education and in social work publicity throughout the United States. It is full of ideas for maintaining

a live relationship with the public.

The Council publishes a series of how-to-do-it bulletins giving simple principles for the successful use of various publicity media, including: Photographs and How to Use Them; Annual Reports and How to Improve Them; and other bulletins on various ways of reaching an audience, such as letters, radio, and newspapers.

Its collection of folders, reports, and booklets put out by health and social agencies, maintained in cooperation with the Russell Sage Foundation, is available in portfolios, arranged by subject, to any member agency on a loan basis.

Membership is open to individual workers as well as organizations, and the Council's services and publications are addressed to the busy executive who has no training at all in publicity skills, just as much as they are to publicity directors. Publications may be purchased by nonmembers. Information about the Council's services or about its various types of membership may be obtained from Catherine Emig, extension secretary, Social Work Publicity Council, 130 East 22 Street, New York, New York.

# Venereal Disease Program for Rejectees

By HATTIE B. MOORE, R.N., AND EVELYN R. DILL, R.N.

**W**HEN THE registration of men for Army service began in October 1940, a coöperative plan for venereal disease control was developed by the Army and the Bureau of Venereal Disease Control of the New Jersey State Department of Health. The Health Department assumed responsibility for the laboratory examinations of blood specimens and smears, and for the follow-up of those men who were rejected for military service because of positive tests.

A letter is sent to each rejectee requesting the name of his physician, and those who state that they are not able to afford private medical care are referred to the clinic nearest their homes. If a man is already under treatment, no special investigation is made, since a routine procedure for following up reported cases of early syphilis has existed for some time. The name of each man who has not responded to the letter or who has failed to report to his physician or clinic is sent to the local health officer or the public health nurse working in the venereal disease program in that community. Every effort is made to insure treatment for those found to be infected, and many are interviewed for information regarding contacts—including sources of infection.

Beginning in July 1941, public health nurses from the Bureau of Venereal Disease Control were stationed at the Army pre-induction stations in Newark, Camden, and Trenton, to interview all selectees rejected in this second examination because of venereal disease infection, before they returned home. The majority of these were men who had contracted gonorrhea after the examination by the local board or whose infec-

tion was not detected in the first examination.

After Pearl Harbor, the Army officials eliminated all but very cursory examinations by the local draft boards and set up two induction stations at Camden and Newark, where selectees are given a thorough physical examination including tests for venereal disease. Through the Bureau of Venereal Disease Control, a laboratory was set up at each station to do Mazzini tests for syphilis and the microscopic examinations for gonorrhea. The results of these tests are available within a few hours.

Upon rejection, the man is referred by the medical examining officer to the public health nurse. One or two nurses are on duty six days a week at each station. The nurse discusses with the rejectee the result of the test and the need for further medical care, with special consideration for the emotional reaction caused by rejection, tentative diagnosis, and the possibility of social complications. She refers him to his private physician or the nearest clinic for additional medical service. A form letter giving a report of the test made at the pre-induction station, together with a report card and return franked envelope, is sent the same day to the physician or clinic selected, with the request that the doctor report his findings to the State Department of Health. If the physician fails to make a report, or notifies the Department that the rejectee has not appeared at his office, a follow-up visit is made to the patient.

The nurse interviewing the rejectee is aware of her responsibility for the health of the civilian population and attempts to secure the patient's coöperation in

planning for the examination of sex contacts. Sometimes only meager information is given, but whenever adequate identifying information is available, it is reported immediately to the Bureau of Venereal Disease Control and is relayed to the proper health authorities in the state, or in other states, without disclosure of the name of the person supplying the information. In this way contacts are followed up routinely, examined, and treated.

Since April 27, 1941, a public health nurse has been on duty at the cantonment hospital at Fort Dix for interviews regarding contacts, with men who have become infected with venereal disease after joining the Army and who are under treatment at the hospital. The follow-up procedure described above is followed in reaching contacts of these men.

Of the 771 patients interviewed at Fort Dix as of March 1, 1942, there were 721 who gave some information regarding their contacts. In 412 instances the information was considered

definite enough to warrant investigation. Even the indefinite information given by others—such as the frequent statement that the contact was a pickup in a certain locality in Trenton, Philadelphia, or New York—is of some value as an indication of where closer supervision is needed. Of the 412 contacts investigated, 99 were in New Jersey and 313 in other states. A great majority were in New York City or Philadelphia—cities which attract many soldiers on leave from Fort Dix.

The procedure of interview and followup as carried on in New Jersey has many advantages. Loss of time, duplication of effort, and loss of patients through referral are reduced to a minimum. A relatively high number of sources and contacts of venereal disease infection are discovered and treatment begun promptly. At this time when good health is vital to the nation, and when economy and efficiency in health programs are necessary, we believe this program is an important contribution to civilian defense.

#### ADDITIONAL SUMMER COURSES

The National Society for the Prevention of Blindness sponsors sight-saving courses for the training of teachers and supervisors of sight-saving classes at:

Wayne University, Detroit, Michigan	June 29—August 7
State Teachers College, Buffalo, New York	June 29—August 7
Teachers College, Columbia University, New York, New York	July 6—August 14
George Peabody College for Teachers, Nashville, Tennessee	June 22—August 1

For further information regarding the courses write to the university or college at which the courses are given.

#### Minnesota.

**Minneapolis. University of Minnesota.** The following courses in the Kenny method of the treatment of early poliomyelitis are being given under the supervision of Dr. Miland E. Knapp, director of the Department of Physical Therapy: (1) A course of one week's duration to be repeated at various times in the next six to twelve months is offered to nurses in key positions in communicable disease hospitals, and is intended to train the nurse only in the preparation and application of the Kenny Hot Foments. (2) A course of from two to six months' duration for nurses in teaching institutions and for registered physical therapy technicians, preferably graduate nurses, was started on April 13, and new students may be accepted on May 11 and June 15 if openings are available. The class is

(Continued on advertising page 13)

# Do You Doubt Value of Lay Committees?

By DOROTHY D. STEWART, R.N.

**A**T THIS TIME of grave emergency when both nursing power and lay effort must be used to the maximum, the work of lay committees in the public health program assumes new importance.

Lay nursing committees have been utilized in Chautauqua County, New York, for many years. In 1939 it became evident that these committees were not effective because their interest was in too narrow a field and their membership was not representative of the communities. It was decided that new committees should be organized so that these limitations might be minimized. The town was selected as a unit because it was believed that educational work should begin at the "grass roots" rather than at some higher level.

The specific objectives are: (1) to interest and educate local communities in public health (2) to broaden interest in public health nursing service (3) to assist field nurses in their work.

## REPRESENTATIVE GROUP ESSENTIAL

Procedure in organization is as follows. The county public health nurse visits the local health officer to obtain his permission and receive his suggestions for the formation of such a group. The local nursing chairman is then visited. The purposes and functions of the proposed organization are explained to her and her aid solicited. If she agrees to such an organization in her township, a conference is arranged when key people may discuss the plan with the supervising nurse and the county public health nurse.

At this conference, arrangements are made for another meeting to be held in a public building in the evening when

men can attend, if those present agree that it would be desirable. Plans are based on the premise that a committee of this sort, to be effective, must be representative of all groups of citizens. A list of organizations in the township is presented, with the names of their presidents or presiding officers. The list is divided among those present at the conference and they are asked to communicate with the organization heads as soon as possible to explain the purpose of the meeting, and to invite them and other members of their groups to attend. Typical of participating organizations are the American Red Cross chapter, home bureau, women's club, church societies, American Legion auxiliary, firemen, lodges, business men's club, and granges.

At the evening meeting, the nursing chairman for the township presides and explains the purpose of the proposed organization. The nursing supervisor and the nurse serving the district also discuss the project. After a clear understanding has been reached, the audience is asked to vote on whether an organization of this kind would be effective for their township. If the vote is negative the matter is dropped temporarily; if affirmative, officers are elected and the permanent head takes the chair.

## SUBCOMMITTEES ARE ACTIVE

When the basic organization is established, the subcommittees begin to function. Subcommittees are organized for specific purposes such as assisting with child health conferences, transporting children, purchasing and making supplies for the nurses, raising funds, and arranging loan closets. A program committee has charge of arranging the pro-



gram for a year. Speakers are booked through the speakers' bureau of the county medical society and other sources. During the first year of organization the subcommittees sometimes undertake promotional work. For example, they may recommend to their board of health that child health conferences be established, or that laboratory service or nursing service be expanded.

Some of the committees during the second year of organization have made community surveys, using the form which is used by the public health nurses. The information for completing the survey is obtained from speakers invited to address their regular meetings. The town supervisor discusses town finances; the local health officer, his duties, local vital statistics, and other facts about local health needs and program; the district engineer, water supplies, sewage disposal, and milk sanitation; the district health officer, public health organization at the state, county, and local level; the local public health nurse, nursing service; and the laboratory director, laboratory service.

The organization of these lay nursing committees is not a simple matter. Many difficulties associated with committee organization of any type arise. In towns that are already over-organized, another organization is not likely to be successful and may not be advisable. One problem that has arisen is the use of the word "committee" for describing the organization. Many people consider that a committee is limited to a select few, and that interest cannot be awakened in the community as a whole. Although the term "committee" is used in this article, the name "Health Service Organiza-

tion" is employed locally for the groups.

At present there are 14 Health Service Organizations functioning in the 27 towns of Chautauqua County. Eventually these groups will be organized at the county level. The existing committees have functioned satisfactorily. Some of their accomplishments are as follows:

Twenty women from these groups appeared before the county Board of Supervisors in 1940 and requested the appointment of a fourth county public health nurse. The request was granted and became effective in June 1941.

In areas where child health conferences have not been instituted the committees have been instrumental in motivating the town boards to start them. In towns where child health conferences are established, committees have assisted in various ways. For example, two members of a committee assist the nurse at the monthly conferences. One member is responsible for making appointments for the dental hygienist as well as assisting her at the conference. The committee provides transportation to the conference for mothers and children who are unable to come otherwise.

Two towns chose to make a survey of their townships in 1940, and as a result they have become aware of the need of county laboratory service and are endeavoring to interest their town boards in this activity.

During 1940 the organizations sponsored 27 public meetings with a total attendance of 661. Topics discussed were accident prevention, syphilis, pneumonia, poliomyelitis, cancer, public health administration, child health, and maternity.

**Biennial Convention, Chicago, Illinois, May 18-22, 1942**

## Congress on Obstetrics Meets

A COMMON interest in maternal care brought together a group of physicians and nurses from various fields of service—hospitals, private practice, and public health—for The Second American Congress on Obstetrics and Gynecology, which met in St. Louis, Missouri, during the week of April 6.

The general or joint sessions of the Congress were devoted to subjects dealing with various aspects of maternal care of mutual significance to the medical and nursing profession—subjects varying from chemotherapy, shock and hemorrhage, genital cancer, and control of eclampsia, to the economics of obstetrical care. The "Information Please" technique, utilized throughout the Congress in connection with these general sessions, was particularly appropriate and effective because of the many experts who were present at the meetings. Clinical conferences, demonstrations, scientific and educational exhibits, motion picture programs, and opportunities for personal consultation were provided on all phases of maternity service.

One separate meeting of the nursing section dealt with needs arising from national defense and another with preparation of the nurse for teaching patients in various settings such as hospitals, outpatient departments, and public health agencies.

Community nursing services were discussed at a joint meeting of the Public Health and Nursing Sections, including

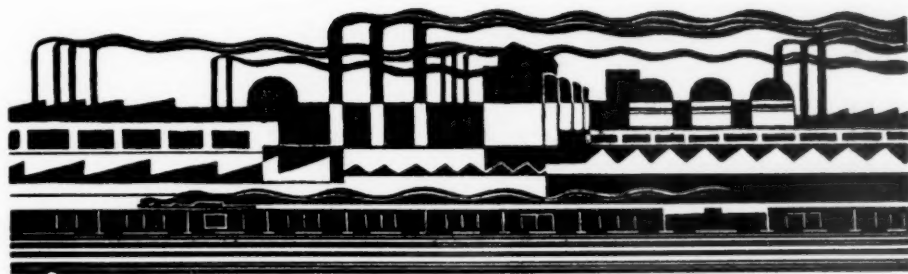
the education and services of nurse midwives and the maintenance of standards during the war emergency.

The effect of war on maternal health services was the theme of a public health round table conducted on the first day of the Congress. Reports by local public health officials from various centers of military and industrial activity gave all too vivid a picture of the effects of withdrawal of health personnel, combined in many instances with chronically meager community facilities for health services. A review of counties having defense activities, made by the U. S. Children's Bureau as of January 1941, was reported as revealing nearly 500 counties where public health services for mothers and children were inadequate; about 250 where there were no antepartum clinics under health department administration; nearly 200 without a baby clinic; and 89 without any public health nursing whatever. Similarly, great lacks were revealed in many counties with respect to hospital beds for obstetrical patients as well as resident restrictions and hospital discharge policies which affect the availability and quality of maternal care.

As is usually the case when so much that is stimulating and informative is presented in a few days, one regrets what had to be missed and the inability to share adequately what was offered with those who could not come to hear and see for themselves.

H. H.

CALLING all Charter Members of N.O.P.H.N.! Charter Members who have not received a card from the National are asked to let us know whether they plan to attend the Biennial and to send us their present addresses. A special table is being reserved for Charter Members at the Membership Rally Luncheon, Tuesday, May 19, at the Palmer House, Chicago, when we celebrate the Thirtieth Birthday of the N.O.P.H.N.



## State Consultants Serve Industrial Nurses

By RUTH M. SCOTT, R.N.

**T**HE SMALL plant which provides a health maintenance program for its workers is an exception, not the rule. Since 62.2 percent of our workers are employed in 98.7 percent of our plants and these are the industrial establishments with less than 500 employees,\* we have a huge problem confronting us.

The cost of adequate health services for these small plants has been considered prohibitive until very recently. Now we are beginning to observe rather frequent gleams of interest here and there from small plants which recognize their health needs and want to do something about them. Several of our plants from 150 to 500 workers have recently secured nurses. The findings of the survey conducted by the National Association of Manufacturers on "Industrial Health Practices," and reported in the September 1941 issue of *Industrial Medicine*, indicated that executives of small companies are giving plant health practices increasing consideration.

The defense program and stepped-up production have focused attention on the

health of the worker and those factors which influence his health. The industrial worker is perhaps the most important person in our defense, and as the wage earner of the family he is also important in the community.

Governmental agencies, recognizing the problems involved, have accepted increased responsibility. The United States Public Health Service has enlarged the scope of its services. Field staff units have been lent by its Division of Industrial Hygiene to states. Trained public health personnel have been given an orientation program by the Public Health Service and lent to states having critical defense areas.

Bureaus of industrial hygiene have existed in many states for some time, and a number of new ones have recently been established.\*\* Eight states now have public health nursing consultants functioning in the field of industrial hygiene.

Since suitable industrial nursing service seems to be an answer to the health needs in many small plants, the public

\*Public Health Bulletin No. 259. "A Preliminary Survey of the Industrial Hygiene Problem in the United States." Federal Security Agency, United States Public Health Service, Washington, D.C.

\*\*Thirty-six states, four cities, two counties, and two territories have industrial hygiene programs according to the Division of Industrial Hygiene of the U. S. Public Health Service in January 1942.



The nurse in industry must be skillful and versatile

health nursing consultant on industrial hygiene in the state health department has a particular contribution to make in this field. She must be a person with a broad knowledge of public health. It is an advantage if she has had experience in industrial nursing which will have given her some first-hand knowledge of industrial organization and relationships. She must know the industrial problems within her state and be familiar with the public health resources available. With this background she can really be effective in her relationships with her own bureau of industrial hygiene, with the state public health nursing consultants and supervising nurses, and directly or indirectly with local public health personnel and industrial establishments.

Just as it is sound to help a family become self-sufficient and solve its own problems, it is sound to assist local public health organizations to recognize and meet the industrial hygiene problems within the community. The nursing

phase of this education necessarily begins with the public health nursing consultants and supervisors on the state level. The nurse consultant who has this special knowledge of industrial hygiene may function in the following ways:

1. By teaching other consultants and supervisors what she has learned about industrial hygiene problems and the possible solution of these problems. Such teaching may take place through:
  - a. Staff meetings
  - b. Field observations
  - c. Individual conferences
2. By giving assistance to other consultants and supervisors on special problems in their areas:
  - a. Through staff meetings
  - b. Through surveys, or analysis of pertinent information from surveys already available
  - c. By supplying information about other agencies
  - d. By special plant visits and observations
  - e. By arranging for additional assistance in special health programs on subjects such as dentistry, nutrition, tuberculosis, venereal disease, first aid, and rehabilitation

3. By giving assistance to nonofficial agencies with:

- a. Their staff education program
- b. The extension of part-time services to industry

Consultant nursing service in industrial hygiene rendered by a state health department is very new. And nearly all new ventures in public health come in answer to a need. Probably the most pressing problem at present is the need for adequate health service for the small plant. The consultant nurse is in a strategic position to guide the thinking of the local supervising nurse regarding the industrial problems in her community. It may be necessary—depending upon the specific situation—to render consultant service directly to a local or county nurse.

A fine example of a county nurse's alertness was displayed a few years ago when our Bureau of Industrial Hygiene was very new. This nurse observed that most of the men patients with diagnosed tuberculosis in the area had at one time or another worked in a certain small foundry. The two physicians on call for the plant were approached but nothing happened. The situation was reported to the Bureau of Industrial Hygiene. A survey was made and certain changes recommended. There seemed to be little indication that the owner and manager of this small plant had much concern for the health of his employees. The nurse felt this keenly when she tried to solicit his interest in carrying on a tuberculosis program within the plant. About this time, however, a vacancy occurred on the executive board of the county tuberculosis association. The owner of the foundry was elected to the office, which he accepted. The result is an industrial problem being met, and an influential man interested in the health of the community.

Just as we have approached family problems in the past, we begin with the

recognized industrial health needs in a community and proceed from there. Through staff meetings, field observations, and individual conferences, the district or local supervising nurse may be prepared for the following activities in her community. Obviously most of these activities should be approached thoughtfully and with careful planning:

1. Analysis of plants in the community according to size
2. Evaluation of the local industrial hygiene situation in each plant
  - a. Size of plant
  - b. Products manufactured
  - c. Hazards involved
  - d. Medical program
  - e. Nursing program
  - f. Management's interest in the health and welfare of workers, and its interest in the community health
3. Program-planning on a long-time basis for each plant according to its apparent need
  - a. Medical service—full-time, or part-time, or consultant
  - b. Adequate nursing service—full- or part-time
    - (1) First aid
    - (2) Health supervision in and out of plant
    - (3) Community cooperation
4. Promotion of industrial hygiene in plants of all sizes
  - a. Pre-employment examination and re-examination
  - b. Suitable placement of employees
  - c. Occupational disease control
  - d. Special health programs
5. Consultant services to nurses employed in plants—especially new nurses
  - a. Assistance with educational programs to stimulate workers to use health service
  - b. Plans for the scope of general health service
  - c. Use of available community resources
6. Direct consultation services to plants on nursing problems
7. Arrangement for part-time nursing service through the visiting nurse association or the official agency

The full-time plant nurse will perhaps be the solution to the health problem in many small industries. With the arrival of the nurse, plant management may be inclined to feel immediately that the health of the worker is under perfect



control. But the nurse, except for first-aid procedure, has had no preparation in what is expected of her in an industrial situation. Little or nothing of industrial hygiene is included in the basic curriculum in schools of nursing. A public health background is a help in many instances. However, it is only recently that the intricacies of industrial organizations, their health service, and the nurse's place in the picture have been included in the public health curricula of a few universities.

To meet the present need for knowledge, nursing organizations are providing programs on industrial nursing. Industrial nurses themselves are forming sections or study groups and a number of such organizations have been in existence several years. The generalized public health nurse can learn much by attending these programs if she has an opportunity. All such group meetings are to be encouraged. A few state health departments have initiated staff development conferences on industrial nursing

with other interested organizations cooperating. The method is not important so long as the community and the industry benefit from extended and improved services.

New state public health nursing consultants who are beginning their services in industrial hygiene may be sure that industries are interested in the health of their workers as never before. New nurses in industry are eager for assistance from someone who understands their special problems. There are many other groups vitally interested in industrial health. May we utilize all these contributing factors with courage and wisdom! Perhaps then we shall have achieved sufficiently improved industrial health practices to last beyond the present defense era.

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Presented before the Joint Session of the Industrial Hygiene and Public Health Nursing Sections, Annual Meeting, American Public Health Association, Atlantic City, New Jersey, October 15, 1941.

The picture is by courtesy of The Visiting Nurse Society of Philadelphia, Pennsylvania.

## INDUSTRIAL NURSING AT THE BIENNIAL

SEVERAL authorities in the field are to participate in the preconvention group conference on Industrial Nursing on Saturday, May 16, and Sunday morning, May 17. Registrations for this conference should reach the N.O.P.H.N., 1790 Broadway, New York, N.Y., by May 11. There is no registration fee. The conference will be held at the Palmer House, Room 18, club floor. The Saturday conference begins at 9:30 a.m.

Monday is a day of special interest to industrial nurses. One of the most important meetings of the Convention is the session on "Newer Treatment of War Injuries," by Dr. Philip D. Wilson, at

10:45 a.m. The luncheon sponsored by the Industrial Nursing Section is at 12:30 p.m. The round table on industrial nursing and the business meeting of the Section are to be held at 4:30 p.m.

Many of the later sessions will also be of value to nurses in industry, particularly the round tables on "Group Teaching" and on "Supply and Distribution of Public Health Nursing Personnel" (Tuesday), the general sessions on "Nutrition and Health" (Thursday) and on "Public Medical Care" (Friday), and the round table on "Tuberculosis" (Thursday).

# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

## HIGHLIGHTS OF N.O.P.H.N. PROGRAM AT BIENNIAL

**M**ANY DIFFERENT facets of "Nursing at the Nation's Service," the theme of the 1942 Biennial Convention, will be explored at the N.O.P.H.N. sessions, May 18-22. The tentative program was published in the April issue, page 220.

"Adjusting to Wartime Needs," the subject of the opening general session on Tuesday morning, May 19, will set the keynote of the meetings to follow. The speakers will be Maynard Krueger, assistant professor of economics, University of Chicago, Chicago, Ill., and Marion Sheahan, director, Division of Public Health Nursing, State of New York Department of Health, Albany, N. Y.

The important subject of "Nutrition and Health" will be given emphasis at the second general session on Thursday morning, May 21, with three speakers—Oris V. Wells, chief program analyst, United States Department of Agriculture, Bureau of Agricultural Economics, Washington, D.C.; Marjorie M. Heseltine, consultant in nutrition, U. S. Children's Bureau, Washington, D.C.; and Erna E. Proctor, regional home economist, United States Department of Agriculture, Farm Security Administration, Montgomery, Ala.

Needs and plans for "Public Medical Care" will be discussed at the Friday morning general session by Michael M. Davis, chairman, Committee on Research in Medical Economics, New York, N. Y., and George St. John Perrott, chief, Division of Public Health Methods, National Institute of Health, Bethesda, Md.

A special session of great interest will

be the one on "Newer Treatment of War Injuries" the first morning of the convention, May 18. The speaker will be Philip D. Wilson, M.D., chief of staff, Hospital for the Ruptured and Crippled, New York, N.Y.

Round tables and other meetings during the convention week will be devoted to topics of particular interest in view of the war emergency, not neglecting the old problems which are still with us, and which are particularly important for the protection of civilian health.

"Warriors All," an address by Samuel A. Goldsmith, executive director, Jewish Charities of Chicago, is the feature of the N.O.P.H.N. dinner sponsored by the Board and Committee Members' Section on Wednesday, May 20, at 7:00 p.m.

Four important luncheons will be:

1. Membership Rally Luncheon—as always a highlight of the Biennial—on May 19.
2. Industrial Nursing Section Luncheon,\* with an address on "Mental Hygiene in Industry," by Eugenia S. Cameron, M.D., medical specialist in mental health, Bureau of Maternal and Child Health, State Board of Health, Madison, Wis., on May 18.
3. School Nursing Section Luncheon Business Meeting, on May 20.
4. Luncheon of the Board and Committee Members' Section, with a talk on "Volunteers" by Evelyn K. Davis on May 21.

Demonstrations of Nursing Care of the Premature Infant are planned at Cook County Hospital, the City of Chicago Health Department, and the Michael Reese Hospital, through the courtesy of their nursing staffs. Demon-

\*Tickets for the Industrial Nursing Section Luncheon will be sold on Sunday, May 17, at the Ticket Booth, Stevens Hotel.

strations of Home-Delivery Setup will be offered at Chicago Maternity Center. A limited number of tickets for these demonstrations will be available at the N.O.P.H.N. exhibit booths, 24 and 25, at the Stevens Hotel. N.O.P.H.N. members will be given first opportunity to attend. See the official convention program for further details.

For hotel reservations see March issue, page 167.

For railroad, bus, and airline fares see April issue, page 222. Prices of Pullman berth accommodations have increased 10 percent over the figures quoted in the magazine, according to recent information from the railroads.

An informal tea for board and committee members is arranged for Monday afternoon in the Board Members' Lounge at the Palmer House. Board members of the Chicago Visiting Nurse Association and the Infant Welfare Society of Chicago will be hostesses at a tea for the Board and Committee Members' Section on Wednesday afternoon at the Historical Society, Lincoln Park.

Be sure to bring your N.O.P.H.N. membership card to the convention. N.O.P.H.N. business meetings and other opportunities are open to members of the organization upon presentation of membership card.

#### PRECONVENTION CONFERENCES

**L**EADERS for the N.O.P.H.N. group conferences on Saturday and Sunday, May 16 and 17, preceding the Biennial Convention, are as follows:

- Business Administration—Emilie G. Sargent, director of the Visiting Nurse Association of Detroit, Detroit, Mich.
- Eye Health—Eleanor W. Mumford, associate for nursing activities, National Society for the Prevention of Blindness, New York, N. Y.
- Industrial Nursing—Joanna Johnson, supervisor of the Industrial Nursing Division, Employers Mutuals, Milwaukee, Wis.
- Methods of Group Teaching—Frances H. Benjamin, consultant in parent education, State Department of Health, Lansing, Mich.
- Nutrition—Marjorie M. Heseltine, consultant in nutrition, U. S. Children's Bureau, Washington, D. C.
- Orthopedic Nursing: Section A—Carmelita Calderwood, consultant in orthopedic nursing, National

- League of Nursing Education, New York, N. Y.
- Orthopedic Nursing: Section B—Jessie L. Stevenson, consultant in orthopedic nursing, N.O.P.H.N., New York, N. Y.
- School Nursing: Elementary—Lula P. Dilworth, associate in health and safety education, Department of Public Instruction, Trenton, N. J.
- School Nursing: Secondary—Gertrude E. Cromwell, supervisor health education and school nursing, Des Moines Public Schools, Des Moines, Iowa. (The two conferences on School Nursing may be combined.)
- Social Hygiene—Donna Pearce, public health nursing consultant, U. S. Public Health Service, Johns Hopkins Hospital, Baltimore, Md.

The final date for receiving preconvention registrations has been extended from May 1 to May 11. If you plan to attend any of these conferences, please send your application and registration fee to the N.O.P.H.N., 1790 Broadway, New York, N.Y., as soon as possible.

The quotas for the Orthopedic Nursing conferences are filled, and registrations for these conferences have closed.

The Business Administration conference was originally open only to one representative from each member agency. Additional representatives from an agency will be admitted, however, if the quota is not filled by May 11.

The tentative program for the conferences with detailed information appeared in the January 1942 issue.

#### FIELD SERVICE

**F**IELD VISITS to communities in several states were made by N.O.P.H.N. staff members during the latter part of March and the month of April.

Two meetings in Washington D. C., were attended by Ruth Houlton on March 13, 17, and 18—a meeting of the Inventory Committee of the Subcommittee on Nursing, Health and Medical Committee, Office of Defense Health and Welfare Services; and a meeting of the Advisory Commission on Children in Wartime of the U. S. Children's Bureau. On April 11 Miss Houlton participated in a round table for the industrial hygiene nursing consultants of several states, which was conducted by Olive M. Whitlock of the U. S. Public Health Service at the National Institute of Health in Bethesda, Md.

Hortense Hilbert represented the

N.O.P.H.N. at The Second American Congress on Obstetrics and Gynecology held in St. Louis during the week of April 6, and spent a week later in April participating in a community survey of the Oranges and Maplewood, N. J., conducted by Community Chests and Councils, Inc. Other field services included a talk at the twelfth New England Health Institute in Providence, R.I., on April 21, and two talks in Stamford, Conn., on April 29—at the spring meeting of the Connecticut State Nurses' Association, and at a joint meeting of the S.N.A. and the Board Members' Organization of Connecticut Public Health Nursing Associations.

During April, visits were made by Mary C. Connor to the University of Pittsburgh and the University of North Carolina, to a conference at the U. S. Public Health Service in Washington, D.C., and to a meeting of the State Department of Health in Albany, N.Y.

On April 21 Ella L. Pensinger met with the Nursing Committee and the

*(Continued on advertising page 14)*

#### MRS. BIGLER RESIGNS

ON JUNE FIRST Mrs. D. Irene Bigler, assistant director and consultant in industrial nursing, will resign from the N.O.P.H.N. staff. For the immediate future Mrs. Bigler plans to combine teaching and lecturing on industrial nursing with study to complete work for her master's degree.

Mrs. Bigler came to the N.O.P.H.N. staff in April 1941. She has made many friends among industrial nurses throughout the country and has stimulated new activities in relation to industrial nursing on the part of the National Organization.

The N.O.P.H.N.'s best wishes go with her, and also a pledge to her and other industrial nurses that a way will be sought to carry on the work she has started.

#### MRS. BELLOS LENT TO N.O.P.H.N.

Mrs. Sybil Palmer Bellos came to the N.O.P.H.N. on April 15 for some special studies. She is lent for three months to the National by the Westchester (New York) County Department of Health, in which she is assistant director of the Division of Nursing.

#### HONOR ROLL

Let's celebrate the Thirtieth Birthday of the N.O.P.H.N. with the biggest Honor Roll in its history. Every agency should be on the Honor Roll this year.

For your agency to attain Honor Roll standing, just be sure all the nurses on your staff (one-nurse agencies too) are enrolled in the N.O.P.H.N. for 1942. Then drop us a card telling us you are 100 percent. We'll make sure a Certificate is sent to you immediately, and the name of your agency will appear on the next list to be published.

##### ALABAMA

Marion County Health Department,  
Hamilton

##### COLORADO

\*Colorado Tuberculosis Association, Denver

##### FLORIDA

Dade County Health Department, Miami

##### GEORGIA

Thomas County Health Department,  
Thomasville

##### ILLINOIS

Metropolitan Life Insurance Nursing  
Service of Cairo, Cairo

\*Visiting Nurse Association, Evanston

##### INDIANA

Crawford County Nursing Service, English

\*Red Cross Public Health Nursing Service  
of Allen County, Fort Wayne

##### IOWA

Humboldt County Nursing Service, Dakota City

##### KENTUCKY

Meade County Health Department,  
Brandenburg

\*Agencies which have been on the Honor Roll for five years or more.

**KENTUCKY** (continued)

Edmonson County Health Department,  
Brownsville  
Scott County Health Department, George-  
town  
Breckinridge County Health Department,  
Hardinsburg  
Estil County Health Department, Irvine  
\*Metropolitan Life Insurance Nursing  
Service, Madisonville  
Campbell County Health Department,  
Newport  
Metropolitan Life Insurance Nursing  
Service, Newport  
Bourbon County Health Department,  
Paris  
Bed County Health Department, Pine-  
ville  
Livingston County Health Department,  
Smithland

**LOUISIANA**

Tensas Parish Health Unit, St. Joseph

**MASSACHUSETTS**

\*Board of Health, West Springfield

**MINNESOTA**

St. Louis County Nursing Service, Aurora  
Mower County Nursing Service, Austin  
Otter Tail County Sanatorium, Battle  
Lake  
School Nursing Service, Bemidji  
Teachers College, Bemidji  
Swift County Nursing Service, Benson  
Crow Wing County Public Health Nurs-  
ing Service, Brainerd  
Mineral Springs Sanatorium, Cannon  
Falls  
Cass County Indian Service, Minnesota  
Department of Health, Cass Lake  
School Nursing Service, Columbia  
Heights  
School Nursing Service, Crosby  
Polk County Nursing Service, Crookston  
School of Agriculture Nursing Service,  
Crookston  
Sunnyrest Sanatorium, Crookston  
\*Metropolitan Life Insurance Nursing  
Service, Duluth  
\*State Teachers College Nursing Service,  
Duluth  
Martin County Nursing Service, Fair-  
mount  
School Nursing Service, Faribault  
Dakota County Nursing Service, Farm-  
ington  
Sibley County Public Health Nursing  
Committee, Gaylord  
The Kittson County Nursing Service,  
Hallock  
School Nursing Service, Keewatin  
Todd County Nursing Service, Long  
Prairie

Teachers College, Mankato  
Flour City Ornamental Iron Company,  
Minneapolis  
Industrial Nurse Service, Federal Reserve  
Bank, Minneapolis  
Industrial Nurse Service, Land O'Lakes,  
Minneapolis  
Industrial Nurse Service, Powers Mercan-  
tile Company, Minneapolis  
Industrial Nurse Service, Street Railway  
Company, Minneapolis  
\*Division of Child Hygiene, State Depart-  
ment of Health, Minneapolis  
School Nursing Service, Nashwauk  
Mahnomen County Indian Service, Min-  
nesota Department of Health, Naytah-  
waush  
U. S. Indian Service, Onamia  
School Nursing Service, Owatonna  
School Nursing Service, Pipestone  
Fillmore County Health Department,  
Preston  
Goodhue County Nursing Service, Red  
Wing  
Teachers College Nursing Service, St.  
Cloud  
Nicollet County Nursing Service, St.  
Peter  
St. Peter School Nursing Service, St.  
Peter  
School Nursing Service, Sauk Center  
School Nursing Service, Two Harbors  
Buena Vista Sanatorium, Wabasha  
Infant Welfare Service, Winona  
School Nursing Service, Worthington

**MISSOURI**

Cooper County Public Health Nursing  
Service, Boonville  
Howard County Nursing Service, Fayette  
State Health Department, Higginsville  
Clay County Public Health Nursing  
Service, Liberty  
Pettis County Public Health Nursing  
Service, Sedalia  
Johnson County Nursing Service, War-  
rensburg

**NEBRASKA**

Demonstration District Health Unit No.  
1, Gering

**NEW JERSEY**

\*Visiting Nurse Association, Trenton

**NEW MEXICO**

\*Lincoln County Health Department, Car-  
rizozo  
\*Lea County Health Department, Loving-  
ton  
\*Harding County Health Department,  
Mosquero  
Valencia County Nursing Service, Los  
Lumas

(Continued on advertising page 14)



## N.O.P.H.N. BALLOT

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|--|---|
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| <input type="checkbox"/> Arthur J. Jones, Ph.D., Philadelphia, Pa.     | <input type="checkbox"/> Dorothy G. Wiehl, New York, N.Y.                 |

\* Representatives of boards and committees of local public health nursing organizations.

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|---|--|
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† For reelection.

Biographical data in regard to the candidates has been sent to the members with the final ballot.



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EDITED BY EVELYN C. NELSON

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#### NUTRITION IN HEALTH AND DISEASE

By Lenna F. Cooper, M.A., Edith M. Barber, M.S., and Helen S. Mitchell, Ph.D. 710 pp. J. B. Lippincott Company, Philadelphia, eighth edition revised, 1941. \$3.50.

This book, like previous editions, is designed especially for the nursing profession. It covers briefly but concisely the principles of nutrition and the dietary treatment of disease. Of necessity, the statements are factual and very much condensed. A rather large section of the first 400 pages deals with diet in abnormal conditions but it is preceded by discussions of metabolism and of the nature of food materials. The topics of dietary standards and allowances of specific nutrients lead to a brief exposition of the selection and sanitary care of food.

Nutrition in public health programs and racial food habits comprise Part IV—about eight pages—while recipes and cookery are treated in considerable detail. The food tables are excellent, the figures being given in grams per 100 grams and spread across two pages to include all nutrients. Additional tables which contribute to the usefulness of the book are: classification of foods according to carbohydrate content; equivalent weights and measures; numerical constants pertaining to food and common physiologic and pathologic values in the human.

While the authors doubtless recognize the danger of engendering an overpositive attitude in students by the presentation of conclusions without the evidence for and against them, they have succeeded in giving a true and interesting summary of the accepted findings in nutrition and diet therapy.

HELEN B. THOMPSON  
*Los Angeles, California*

#### COMMUNITY HYGIENE

By Dean Franklin Smiley, M.D. and Adrian Gordon Gould, M.D. 448 pp. The Macmillan Company, New York, third edition, 1941. \$2.50.

This is a comprehensive and up-to-date textbook for college students which can be recommended for teachers and students concerned with the problems of modern medical and sanitary science. This edition follows somewhat the original plan of presentation of material, but the authors have made revisions in Section V on Health Agencies and have added data relating to industrial and military problems.

The student will find this volume authentic and easy to read. It contains many excellent graphs and illustrations. Those wishing a more critical discussion or additional information will find an excellent bibliography and references at the conclusion of each chapter.

ELEANOR W. MOLE, R.N.  
*New York, New York*

**YOUR PERSONALITY—INTROVERT OR  
EXTRAVERT?**

By Virginia Case. 277 pp. The Macmillan Company, New York, 1941. \$2.50.

The author's purpose in writing this book is clarified in two statements: "This book is intended to help you understand your neighbor and yourself." "It is with the hope of correcting current misunderstanding and of making available to the general public the helpful practical knowledge of human nature which Jung's work supplies in abundance. . . ."

Miss Case is said to have studied in Dr. Jung's seminar in Zurich and should therefore be particularly well qualified to interpret his views on introversion and extraversion. She states in her Introductory Note that Dr. Jung had read the book in manuscript form and consented to its publication.

The author has presented much more than a superficial view of introversion and extraversion. The book enlarges one's understanding of the part that extraversion and introversion are thought to play in satisfactory life adjustments. It also gives the characteristic behavior which the author believes each type of personality exhibits under a variety of circumstances.

Some of the descriptive terms, such as "altertendency" and "mind-ego," may be rather difficult for popular understanding. Not everyone will agree with certain of the author's generalizations, on the ground that they are not based on a sufficiently large number of cases or that some of the observations are not made by trained observers. One such generalization concerns the important role played by introversion and extraversion in a happy marriage relationship.

This volume should be of value as a general reference for students of psychology, mental hygiene, or psychiatry, to enlarge their knowledge of behavior

common to introvert and extravert types of personality.

MARION J. FABER, R.N.  
*Chicago, Illinois*

**TUBERCULOSIS IN INDUSTRY**

Report of the Symposium Held at the Saranac Laboratory for the Study of Tuberculosis, Saranac Lake, New York, June 9-14, 1941. 374 pp. National Tuberculosis Association, New York, 1942. \$3.

This book has special value for public health nurses. The report is sponsored by the Trudeau School of Tuberculosis and edited by Dr. Leroy U. Gardner, a well known expert on tuberculosis in industry. Twenty-eight authors have participated. In the closing chapter Dr. Gardner summarizes their contributions. The book is divided into six sections, covering fundamental aspects of tuberculosis and factors of particular significance in the tuberculosis problem in industry.

The book contains a large amount of highly practical information, which fortunately is well indexed. The public health nurse will be especially interested in the chapters on nutrition, fatigue, tuberculosis in medical students and nurses, case-finding, and the administrative procedures in the control of tuberculosis.

ESMOND R. LONG, M.D.  
*Philadelphia, Pennsylvania*

**THE ART AND SCIENCE OF NUTRITION**

By Estelle E. Hawley, Ph.D. and Grace Carden, B.S. 619 pp. The C. V. Mosby Company, St. Louis, 1941. \$3.50.

This is an elementary text, probably most useful for nursing school courses in foods and dietetics. It includes discussions of normal nutrition, food requirements under special conditions, diet therapy, and the choice, preparation, and serving of food. Elementary but well chosen reference material is listed briefly. Part VI is an appendix which includes a great deal of tabular material of greater or lesser importance. The table of food composition is on the basis

of nutrients per 100 grams of food, and is better arranged than the 100 calorie table in *The Fundamentals of Nutrition* by Hawley and Maurer-Mast.

The book as a whole is much better put together than Miss Hawley's previous one. Much of the material is vividly presented, and some of it would be hard to find elsewhere. The degree of scientific accuracy achieved is unusual for an elementary presentation. Some of the data could have been more carefully chosen. The authors seem unaware, for instance, that cholesterol is to be found in foods of animal origin only. At least, they have quoted without comment the tables found in Twiss' and Greeno's article in the *Journal of the American Medical Association*, 1933, Volume 101, page 1841.

Colored and other illustrations are plentiful and well done. The book as a whole gives an impression of crowding, and not too good coördination. This is not strange in that it attempts to teach physiology and chemistry of nutrition, food composition, cookery, therapeutic dietetics, and hospital practice all in one volume.

RUTH OKEY, Ph.D.  
Berkeley, California

#### PHYSICAL MEDICINE

By Frank H. Krusen, M.D. 846 pp. W. B. Saunders Company, Philadelphia, 1941. \$10.

Although this book is intended primarily for physicians and medical students it is being received with enthusiasm by nurse physical therapists, and orthopedic nurses should find it a valuable teaching aid. The chapters on general and local applications of heat and cold should be interesting and instructive to any nurse. There are many fine illustrations, and the list of references at the end of each chapter is comprehensive. In this book Dr. Krusen has given us an excellent presentation of all phases of physical medicine.

M. M.

#### THE DIAGNOSIS AND TREATMENT OF PULMONARY TUBERCULOSIS

By John B. Hawes, 2d, M.D. and Moses J. Stone, M.D. 260 pp. Lea & Febiger, Philadelphia, 1940. \$2.75.

This book should be of utmost value to everyone interested in any field of pulmonary tuberculosis. Dr. Cabot in his foreword very aptly describes the book in saying that what impressed him most "... is the firm hold on essentials and its corresponding elimination of 'frills.'"

Stress is placed on history taking and review of the earliest symptoms. The method of physical examination is well described. Special attention is paid to differential diagnosis, with a presentation and illustration of non-tuberculous chest conditions. There is a very sensible description of allergy and immunity. The various types of collapse procedures are well summarized, as are other supplementary treatments of value in our armamentarium. The author's discussion of the mental aspects of the tuberculous patient, a phase of treatment much neglected, is to be commended.

R. KYLE BROWN, M.D.  
Greenville, South Carolina

#### INTRODUCTION TO PSYCHOBIOLOGY AND PSYCHIATRY

By Esther Loring Richards, M.D. 357 pp. The C. V. Mosby Company, St. Louis, 1941. \$2.50.

This is the clearest and best formulation of the psychobiological point of view yet to appear in book form. It is sound psychobiology from cover to cover and at the same time on every page appears the distinct personality of the author.

The book sets forth the lecture material utilized by the author in teaching student nurses. This results in a simplicity of material and presentation which is distinctly advantageous for an introduction to psychobiological principles.

Part I is devoted to a brief resumé of the historical background of psychiatry,

an exposition of the point of view of psychobiology, and a review of the materials entering into the personality study.

Part II, which deals with behavior abnormalities, gives a brief discussion of the method of approach, followed by an exposition of the methods of gathering facts. This is succeeded by a review of the principal reaction types presented in the classical psychobiological manner, with the delineation of case history material discussed in terms of the lessons to be learned therefrom. This whole section bears the virtue of direct description of what is looked for and what is to be observed with a minimum

of resort to the use of technical psychiatric terminology.

The ex cathedra and dogmatic style is a personality characteristic of the author which renders her teaching remarkably effective. Unfortunately, it appears with equal stress in discussions concerning materials with which she is thoroughly conversant and careful, and materials with which she seems to be relatively unfamiliar.

It is regrettable that what appears to be rather careless editing detracts from the charm of this volume, and that the index is inadequate.

LAWRENCE F. WOOLLEY, M.D.  
Towson, Maryland

#### RECENT PUBLICATIONS AND CURRENT PERIODICALS

##### DEFENSE

SUGGESTED REGULATIONS FOR RETAIL STORES (Department Stores—Large Specialty Stores) For Blackouts—Air Raids. U. S. Office of Civilian Defense, Washington, D.C.

A WAR POLICY FOR AMERICAN SCHOOLS. Educational Policies Commission, National Education Association of the United States and the American Association of School Administrators, 1201 Sixteenth Street, N.W., Washington, D.C., 1942. 10c per copy.

Educational priorities in the present war emergency are discussed in this publication by the Educational Policies Commission.

LITTLE OSCAR'S FIRST RAID. Lydia Mead. Drawings by Oscar Fabres. Authorized by the Office of Civilian Defense. Garden City Publishing Co., Inc., Garden City, New York. 64 pp. 25c.

This booklet should be suitable for elementary-school children. The instructions for precautions in air raids are very cleverly illustrated.

KEEP 'EM FLYING. 15 pp. IF IT HAPPENED TO YOU. 11 pp. ELEMENT'RY, MY DEAR HOLMES, ELEMENT'RY. 11 pp. National Tuberculosis Association. Available free through local and state tuberculosis associations.

Public health nurses will be interested in these three pamphlets which cover present-day emphasis in tuberculosis programs, facts pertaining to home defense against tuberculosis,

and a discussion of the modern treatment of tuberculosis.

FIRST IN YOUR THOUGHTS. Maternity Center Association, 654 Madison Avenue, New York, 1942. 50c per 100 copies.

A very timely pamphlet. It gives practical suggestions to expectant mothers on necessary preparations in the event of air-raid interference with plans for hospital or nursing care.

REFERENCES ON NATIONAL DEFENSE AND HEALTH IN RELATION TO CHILD WELFARE. CIVILIANS AND NUTRITION. The National Health Library, 1790 Broadway, New York. N. Y. March 1942. Limited number of single copies free upon request.

VENEREAL DISEASE AND NATIONAL DEFENSE. Thomas Parran, Surgeon General, U. S. Public Health Service. VD Folder No. 7. Superintendent of Documents, Washington, D.C., 1941. \$1 per 100 copies.

DEFENSE ON THE VENEREAL DISEASE FRONT. Thomas Parran, Surgeon General, U. S. Public Health Service. *State Government*, Vol. XIII, No. 12, December 1940. The American Social Hygiene Association, 1790 Broadway, New York, N.Y. 5c.

NEW OPPORTUNITIES FOR NURSES. Katharine Faville. *Occupations, the Vocational Guidance Magazine*, February 1942. The Nursing Council on National Defense, 1790 Broadway, New York, N.Y. 5c a single copy, quantity orders at special rates.



# NEWS

## *Highlights on Defense*

### NEWS FROM THE N.C.N.D.

THE Board of Directors of the W. K. Kellogg Foundation has made a grant to the Nursing Council on National Defense to finance the Council's program for the next six months. This grant was made in the hope that the Council can secure some financial assistance in the future from the Federal Government and other sources.

Mr. Edward Robinson, treasurer of The Rockefeller Foundation, has accepted the appointment as treasurer of the Nursing Council on National Defense.

A meeting of the entire membership of the Council will be held on Saturday, May 23, just following the Biennial Convention in Chicago, Illinois. New members of the Council, appointed from the new boards elected by the national nursing organizations at the Convention, will attend this meeting.

As this issue goes to press the Council has just changed its name to National Nursing Council for War Service. The Council's Committee on Educational Policies and Resources has also changed its name to Committee on Educational Policies.

### ABOUT VOLUNTEER NURSE'S AIDES

A "Suggested Outline for Volunteer Nurse's Aide Survey" has been prepared by the American Red Cross for the use of communities in securing information necessary to determine what their quotas of aides should be. The Red Cross suggests that the survey in a community be made by a small working committee with representation from the chapter nurse's aide committee, the medical division of the local office of civilian defense, hospital groups, the nursing

council on defense, or organized nursing groups. It is anticipated that information obtained from questionnaires and from careful personal interviews, following instructions given by the Red Cross, should give a fairly accurate picture of present and future hospital and nursing resources, of the plans for the care of the civilian population in emergencies, and of present and future needs for Red Cross Volunteer Nurse's Aides—which will serve as a guide in determining local quotas.

Additional instructions regarding the approval of hospitals to be used as training centers for Red Cross Volunteer Nurse's Aides have been issued by the Red Cross and the Medical Division of the Office of Civilian Defense. Copies were sent to regional directors and regional medical officers in an instructional letter on March 17. Outlined in this memo are conditions under which exceptions may be made to the ruling in the "Guide for the Training of Volunteer Nurse's Aides," that hospitals used as training centers must be on the approved lists of the American Medical Association and the American College of Surgeons. It is suggested that local nursing groups request information from local chapters or area offices of the Red Cross or from their state chiefs of emergency medical service.

### NUTRITION FILM

A NEW motion picture, "Hidden Hunger," which emphasizes the importance of eating the right foods, is presented by the Office of Defense Health and Welfare Services, Federal Security Agency. This picture, one of a series made possible through the cooperation of private industry, will be shown soon in theaters from coast to coast.

## STUDENTS INCREASE 18 PERCENT

**E**NROLLMENTS in the 1300 state-accredited schools of nursing in the United States had increased from 87,588 on January 1, 1941, to 91,457 on January 1, 1942—an increase of 3869—according to a study made by the National League of Nursing Education and reported in the May issue of the *American Journal of Nursing* (page 563). These figures are broken down by states according to corps areas in the article. Figures are also given in regard to the number of students being admitted to spring classes and the number which schools expect to admit in the summer and fall. An increase for 1942 of approximately 8000 students, or 18 percent, is anticipated over 1941.

## OCD URGES IMMUNIZATION

**T**HE Office of Civilian Defense, at the request of the United States Children's Bureau, is coöperating with the Bureau and with the Conference of State and Provincial Health Authorities of North America in promoting a campaign for the immunization of children against smallpox and diphtheria. Regional medical officers and assistant regional directors in charge of volunteer participation have been requested by the director of the OCD to support health officers in local communities in this activity as a measure for wartime protection of the civilian population.

## AID TO NURSING EDUCATION

**B**ECAUSE of the urgent need for more nurses as soon as possible, the Surgeon General of the U. S. Public Health Service requested a deficiency appropriation of \$600,000 to be added to the appropriation for "Training for Nurses (national defense)" which was passed July 1, 1941. The deficiency appropriation became available March 1, 1942. The primary purpose of this appropria-

tion is to encourage good schools of nursing to admit an additional class of student nurses this summer or to bring forward the admission of their fall classes to June or July.

Some of these funds are to be allotted to the preparation of public health nurses, and 14 universities have applied for aid for summer courses in public health nursing. These programs provide for about 200 additional students. Any university whose program meets the requirements recommended by the National Organization for Public Health Nursing may apply for federal aid.

The funds allotted to postgraduate programs may be used for subsistence and scholarship tuitions for selected applicants and for additional instructional facilities.

The universities which have applied for aid for public health nursing courses in the spring quarter, intersession, and summer session are as follows:

## State, City and Name of School

**California**

Los Angeles, University of California

**District of Columbia**

Washington, Catholic University of America

**Illinois**

Chicago, University of Chicago  
Chicago, Loyola University

**Massachusetts**

Boston, Simmons College

**Michigan**

Ann Arbor, University of Michigan

**Minnesota**

Minneapolis, University of Minnesota

**Missouri**

St. Louis, St. Louis University

**New York**

Buffalo, University of Buffalo  
Brooklyn, St. John's University  
Syracuse, Syracuse University

**Oregon**

Portland, University of Oregon

**Pennsylvania**

Philadelphia, University of Pennsylvania  
Pittsburgh, Duquesne University

**Tennessee**

Nashville, George Peabody College for Teachers  
Nashville, Vanderbilt University

**Virginia**

Richmond, Medical College of Virginia  
Richmond, Professional Institute of College of William and Mary

**Washington**

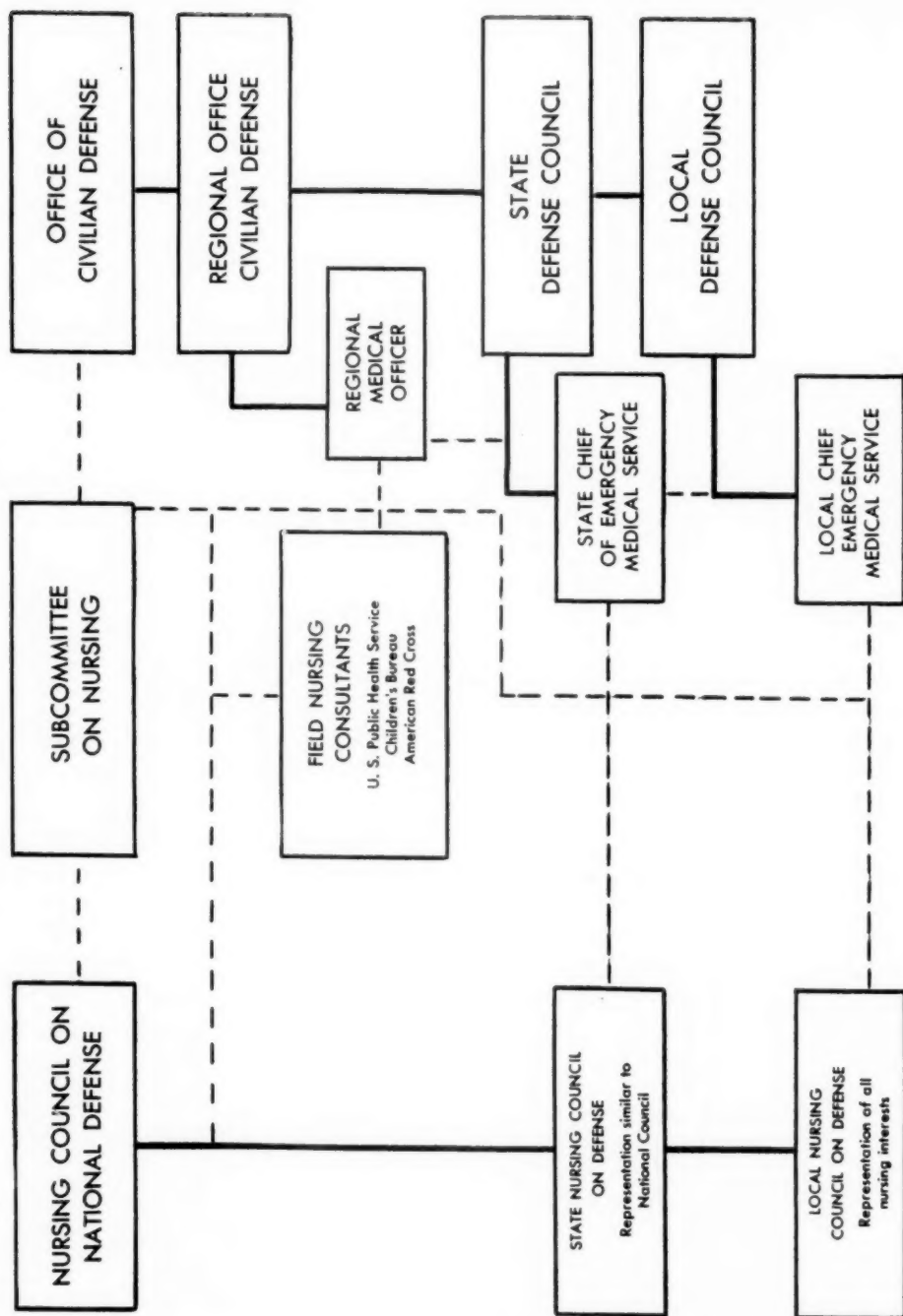
Seattle, University of Washington

**Wisconsin**

Madison, University of Wisconsin

# War Nursing

National, regional, state, and local organization



— organization relationship

- - - cooperative relationship

## *From Far and Near*

• The Association of Collegiate Schools of Nursing will hold its ninth annual meeting in Chicago, Ill., May 15-16.

• The American Home Economics Association will hold its thirty-fifth annual meeting in Boston, June 21-24, with headquarters at the Hotel Statler.

• The Board of Directors of the Birth Control Federation of America, Inc. (501 Madison Avenue, New York, N.Y.), announces the change of its corporate name to the Planned Parenthood Federation of America, Inc.

• Three nurses serving with the U. S. Army in Alaska have been cited in a commendation of the Western Defense and the Fourth Army. They are Maurice G. Wheeler of Hughesville, Mo., formerly a public health nurse with the Metropolitan Life Insurance Company in Missouri; Dorothy Fay McFadden of Tyler, Tex.; and Mary P. Stanton of San Antonio, Tex. The citation was made because of unselfish devotion to duty in evacuating 724 mothers and children from an Alaska outpost in a long and difficult journey to Seattle, Wash., last December. The three nurses have been stationed in Fort Greeley, Alaska, since October 1941.

• Georgia will shortly announce examinations for the following classes, with salary ranges as indicated:

Child Welfare Worker—\$1440 to \$1920; Medical Social Worker, Orthopedic Field Nurse, Physical Therapy Technician, Child Welfare Consultant, and Senior Child Welfare Worker—\$1800 to \$2280; District Ortho-

pedic Field Nurse—\$1920 to \$2400; Senior Child Welfare Consultant and Child Welfare Psychologist—\$2400 to \$2520; Physical Therapy Consultant—\$2400 to \$2880; Senior Child Welfare Consultant, Grade I—\$2400 to \$3000; Orthopedic Nursing Consultant and Medical Social Consultant—\$2700 to \$3180; and Medical Director of the Crippled Children Services—\$4200 to \$5400.

Residence in Georgia is not required of an applicant in order to participate in the examinations. Further details and application blanks should be obtained from the supervisor of examinations, Georgia Merit System Administration—J. A. Boatright, 419 State Capitol, Atlanta.

• The Arizona Merit System Council will soon announce examinations for the following classes of positions, with monthly salary ranges indicated:

State Director of Public Health Nursing—\$215 to \$265; Nursing Consultant in Special Fields—\$175 to \$200; Public Health Nursing Supervisor in Local Health Units—\$150 to \$175 and \$125 to \$150, respectively; Public Health Nurse-in-training—\$100 to \$125.

Further details and application blanks may be secured from the Merit System Council, 208 Home Builders Building, Phoenix. Closing date for receipt of applications will probably be about June 15, 1942.

**CORRECTIONS:** In the column, news from the S.O.P.H.N.'s, March issue, page 167, Evelyn T. Walker is listed as the newly-elected treasurer of the N.O.P.H.N. Council of Branches. This was listed in error. There is no office of treasurer in the Council.

The annual convention of the National Education Association will be held in Denver, Colo., June 27-July 2, instead of June 28-July 2, as stated in the March issue, p. 174.



Scenic spot of 1942 Convention City is Buckingham Fountain, Chicago

## FUNDS NEEDED FOR LEAGUE'S EMERGENCY PROGRAM

**A**N EMERGENCY program to meet the country's need for good nurses to care for our armed forces and our civilian population has been undertaken by the National League of Nursing Education—the professional organization which is primarily concerned with the preparation of nurses. The League's four-part program has for its purpose the protection of the patient and the public through assuring a high caliber of students enrolled in schools of nursing and a high quality of nursing education in the nursing schools. The program includes:

1. The speeding up of the work of surveying schools for accreditation, to the end that young women may be guided into good schools. Now, as never before, it is essential to preserve all that has been gained through years of experience and to see that the effort to make haste does not betray schools into turning out nurses unequal to the emergency.

2. The setting up of a consultation service to schools of nursing and hospital nursing

services, to assist them in making the adjustments necessary to meet the greatly increased enrollment of students and the withdrawal of graduate nurses for the Army and Navy.

3. The conducting of investigations to secure certain facts and figures necessary to the carrying on of these projects. Some of these which are directly related to the emergency are: a study of readjustments necessary in schools to meet present demands; a study of the existing need for nurses, supervisors, and instructors, the present resources, and how to increase them; the construction of tests to aid in determining the selection and preparation of student and graduate nurses; and a study of scholarship and loan funds to assist such students.

4. The discharge of the League's responsibility to the Nursing Council on National Defense. The League is one of the three organizations which finance the work of the Council.

To finance the tremendous increase in its program, the League has launched a campaign for funds, because its present resources—income from dues, fees for surveys, and the sale of publications—



are insufficient to meet these additional responsibilities. The sum required to meet the emergency program is \$100,000 over and above its normal budget for 1942 and 1943.

The appeal was made first to the public rather than to members of the nursing profession. Now, however, an appeal is being made to state leagues and to individual members. They are asked to help in two ways: (1) by appointing themselves each a committee of one to secure one or more contributions from non-league members interested in nursing (2) by sending personal contributions. Checks should be made payable to the

Emergency Nursing Fund, Room 815, 60 East 42 Street, New York, N.Y.

Public health nursing supervisors, educational supervisors, instructors, and administrators are eligible for membership in the League and have joined in increasing numbers during the past few years. They are vitally interested in the sound basic preparation of future public health nurses, and they have a stake in all that the League is working for. They are invited to participate in the League's campaign which will assure the support of this important work at a time when its continuation is essential to the future of nursing in the United States.

## NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

### PLACEMENTS

- \*Miss Ella L. Gilmore, Educational Director, The Visiting Nurse Association, San Francisco, Calif.
- \*Miss Elma Rood, Home Nursing Consultant, American Red Cross Nursing Service, St. Louis, Mo.
- \*Miss Helen M. Flanagan, Nursing Field Consultant, American Red Cross Nursing Service, St. Louis, Mo.
- Miss Margaret Oetjen, Nurse-Midwife Instructor, State Department of Health, Atlanta, Ga.
- Miss Rita A. O'Brien, Township Public Health Nurse, Stickney Township Health Department, Stickney, Ill.
- Miss Irene E. Loge, R.N., Industrial Nurse, Union Special Machine Company, Chicago, Ill.

- \*Mrs. Helene M. Dunham, Staff Nurse (temporary), Metropolitan Life Insurance Company, Chicago, Ill.
- Mrs. Irene T. Kent, Staff Nurse (temporary), Metropolitan Life Insurance Company, Chicago, Ill.
- \*Mrs. Martha Johnson Zeck, Staff Nurse (temporary), Metropolitan Life Insurance Company, Chicago, Ill.

### ASSISTED PLACEMENTS

- \*Miss Dorothy L. Campbell, Director of Nurses, City Department of Health, Evanston, Ill.
- Mrs. Ruby Rogers Freer, Educational Supervisor, City Department of Health, Flint, Mich.
- Miss Elvera C. Brueggmann, Nurse Consultant, American Red Cross Nursing Service, St. Louis, Mo.
- \*Miss Ruth E. Phillips, Nurse Consultant, American Red Cross Nursing Service, Alexandria, Va.
- \*Miss Anna Hassels, Supervisor of Nurses, City Health Department, Green Bay, Wisc.
- Mrs. Marguerite Stough Earl, Staff Nurse, Visiting Nurse Association, Los Angeles, Calif.
- Mrs. Dorothy Moore Tillotson, Staff Nurse, Visiting Nurse Association, Los Angeles, Calif.

\*The N.O.P.H.N. files show that this nurse is a 1942 member.

# The Exhibitors

*Biennial Convention, Chicago, Illinois, May 18-22, 1942*

*The exhibits at the Biennial offer to those attending an unparalleled opportunity to become acquainted with new equipment, new books, foods, and other products of special interest to nurses. The list which follows and the numbers of the booths in bold type provide advance information to help you in planning your examination of the exhibits most effectively. Since the exhibits are to close Thursday night, please make your inspections early.*

## TECHNICAL EXHIBITS

**American Can Co.,** New York, N. Y. **107 & 108.**

**American Hospital Supply Corporation,** Chicago, Ill. and New York, N. Y.

**122.**—See the new, amazingly simple, and safe technic for the preparation, banking, and administration of plasma and serum with Baxter Centri-Vac and Plasma-Vac containers; a new plasma sedimentation technic, particularly adapted for small hospitals; the Transfuso-Vac and intravenous solutions (including sulfanilamide) in Baxter Vacoliters; the Vasocillator (rocking bed); the Dickson paraffin bath; the Tomac Gastro Evacuator; the Myrick bedside sterilizer; the new sheeting material, Tomac Exlyn; and the Tomac plaster bandage machine.

**Artra Cosmetics, Inc.,** Bloomfield, N. J.

**43.**—We will exhibit Sutra, the American Medical Association Accepted sun-filter cream. Sutra is an easily absorbed cream—a shield against painful sunburn, blistering, and peeling. Imra, the modern odorless cosmetic depilatory which involves a new chemical principle in scientific depilation will also be shown.

**Bard-Parker Co., Inc.,** Danbury, Conn.

**131.**—Among other things the new transfer forceps for the aseptic transportation of instruments and supplies to the operating field will be exhibited. Readily picks up any instrument from the smallest suture needle to a heavy retractor. Designed with a pistol grip for easy carrying.

**Becton, Dickson & Co.,** Rutherford, N. J.

**54.**—We will show our standard line of syringes and needles, thermometers, blood pressure apparatus and elastic bandages. There will also be available for you, information relative to the new series of teaching motion pictures, particularly the motion picture on the care and sterilization of hypodermic syringes and needles. We will welcome any inquiry about this subject.

**The Best Foods, Inc.,** New York, N. Y.

**124.**—Interesting displays at this exhibit illustrate and describe the many uses of Nucoa, the wholesome vegetable margarine, composed of products only by American farmers. Nucoa and other Best Foods and Hellmann's products will be displayed at the booth, where Elsie Stark, Director of Home Economics Department, is in charge.

**The BiSoDol Co.,** New Haven, Conn.

**72.**—Every day more and more of your patients will be asking you about an antidote for the war of nerves. At this exhibit you can learn about the effective action of BiSoDol as a pleasant to take antacid alkaliizer. You can carry away useful bits of information, like the fact that one teaspoonful of BiSoDol powder, or three BiSoDol tablets, brings prompt relief in most cases of digestive upset resulting from excess stomach acid.

**The Borden Company,** New York, N. Y.

**115.**—You will find Borden's scientifically improved and sanitarily bottled fluid milks, as well as their scientifically designed infant foods at

Booth 115. Homogenized, Vitamin D, Softened, fresh milks, Biolac, New Improved Dryco, and other infant foods including Mull-Soy for infants allergic to milk. Get a copy of "Plan Before You Eat," a handy vitamin and mineral food chart.

**Bristol-Myers Co.,** New York, N. Y.

**128.**—*Nurses' Hands:* Tounshay, a new beauty lotion, offers unusual protection for hands which are subjected to beauty-destroying routines. Tounshay does more than merely soften skin after it has been immersed in strong, soapy solutions. Applied before daily soap-and-water tasks, Tounshay actually protects hands from roughening, drying effects of immersion. (Tounshay, an emulsion of emollients, contains neither glycerine nor alcohol. It possesses superior qualities as a powder base and is excellent as a fragrant, luxurious body rub.)

**Bruck's Nurses Outfitting Co.,** Chicago, Ill., and New York, N. Y.

**123.**—Student nurses' uniform outfits—uniforms, aprons, bibs, collars, cuffs, caps, accessories (bandage scissors, slips, hose, pearl goods, watches, smocks), public health nurses' uniforms and accessories, spring coats, winter coats, graduate nurses' white uniforms, capes, sweaters, rubber aprons.

**S. H. Camp & Co.,** Jackson, Mich.

**36.**—A life-sized reproduction of the Camp transparent woman will be exhibited as the central theme of a typical service department which is equipped to serve patients for the various supports prescribed by physicians. The complete line of merchandise for prenatal, postnatal, orthopedic, visceroprotic, sacro-iliac, hernial and other specific conditions, will be shown. Experts from the Camp staff will answer specific questions.

**Carnation Co.,** Milwaukee, Wis.

**38 & 39.**—In this exhibit you will see a complete and dramatic presentation of the story of Irradiated Carnation Milk. Every operation in the processing—from farm to finished product—is performed in miniature before your eyes. You will enjoy this personally conducted tour through a Carnation evaporating plant.

**J. & J. Cash, Inc.,** South Norwalk, Conn.

**50.**—This year every doctor, nurse, and student will want every piece of clothing and personal linen marked. Those of you who attend this convention, be sure to stop at this exhibit and see Cash's interwoven name tapes. Their representatives will show you samples of names you will be proud to use. A very extensive selection of styles and colors to choose from.

**The Centaur Co.,** Rahway, N. J. **47.**

**Clay-Adams Co., Inc.,** New York, N. Y.

**136.**—We will exhibit obstetrical manikins featuring the improvements made on the Ayers manikin, and will exhibit also the improved Model N Chase hospital doll, anatomical charts, the muscle skeleton, demonstration skull, and other osteological preparations, as well as other material for nursing education.

# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## New Needs for the Public Health Nurse

**P**ROVISION for nursing care in the home, an urgent need in the present emergency, is the subject of an important recommendation made by the Committee on Health Programs at the Conference of State and Territorial Health Officers, held in Washington, D.C., on March 26, 1942:

The Committee has noted the existing shortage of qualified nurses and a probable inadequacy of hospital facilities. It believes that the deficiencies in both categories are likely to increase rather than diminish. It follows, therefore, that existing resources should be utilized in the most efficient manner possible. Many hospital beds could be made available for cases needing this type of care, if a sufficiency of home nursing care were provided.

Home nursing care on a visiting nursing basis should not only greatly enhance the value of the individual nurse to the community but distribute nursing service more nearly according to the patients' needs. In the opinion of the committee, bedside nursing care is a proper function of a generalized public health nursing service. It should not replace the services usually rendered by public health nurses, but should supplement them. Where a visiting bedside nursing service does not exist, every effort should be made to establish such a service, preferably within an existing official public health agency. Furthermore, the programs of all agencies—public and private—employing public health nurses should be coordinated in order to provide against duplications in nursing service and to utilize most effectively every public health nurse employed. The tendency should be toward consolidation rather than toward the establishment of new organizations to meet recognized needs—toward a pooling of resources rather than a wasteful competition for community support.

Public health nurses and nursing administrators have always realized the importance of bedside nursing care as a

part of the nurse's service in the community. This function of the public health nurse was also recognized by leading public health authorities before the present emergency.

Surgeon General Thomas Parran said at an N.O.P.H.N. dinner in 1937: "It seems to me that a next and needed step is for health departments to provide community nurses who will have responsibility both for prevention and for bedside care, as needed. . . . In the rural areas I see no way by which these needed services can be given except through public funds."

At the 1941 meeting of the American Public Health Association, the commissioner of health of New York City, Dr. John L. Rice, received a burst of applause from the large audience when he said regarding the public health nurse: ". . . we have neglected to make available to her one of her greatest opportunities for effective education. If bedside nursing were a part of her work in the health department, she could do a more telling educational job as well as render a greater service."

Today, nursing care of the sick and injured in the home assumes greater importance than ever before. Plans for the care of civilians injured as the result of air raids or other enemy action provide for reimbursement by the Federal Government to civilian hospitals at a rate of \$3.75 a day, according to a recent release from the U. S. Office of Civilian Defense. Any hospital in the nation, voluntary or governmental, may be used as a casualty receiving hospital in the

Emergency Medical Service established by the Medical Service of the OCD.

Hospitals are already overcrowded, and many are spreading their facilities to reach a larger number of people by discharging patients with certain kinds of illness—including maternity patients on the third to the fifth day after delivery—who can be given nursing care in the home by the public health nursing agency. In the event of incidents which result in casualties, the hospitals will have to be emptied of all convalescent patients and others not acutely ill, in order to take care of the severely injured. These evacuated hospital patients will need care in their homes. Moreover, injured persons who are not hospitalized or who are kept in the hospital only temporarily, will require follow-up visits for care in the home. These are needs which the public health nurses are prepared to meet, and for which, with the present nurse shortage, they will almost certainly be called upon in an emergency.

New importance attaches to the N.O.P.H.N.'s project, started by its Committee on Nursing Administration, to make a study of typical communities in the United States that have no organized service for care of the sick in the home. This project, which was proposed to the National by a special committee of the Nursing Advisory Committee

for the Metropolitan Life Insurance Company Nursing Service—and which is made possible by a limited grant from the M.L.I.—has the interested support of the nursing services of the American Red Cross, the U. S. Public Health Service, and the U. S. Children's Bureau.

Public health nurses are preparing to meet these new needs. Through first-aid classes, they are securing the most recent information on what to do and what not to do for patients with injuries; what symptoms following an injury may be significant; and what to teach the families under their supervision.

In some communities, public health nurses employed in agencies whose program does not include bedside care have requested demonstrations from local visiting nurse associations to bring them up to date on recent and efficient methods of bedside care in the home with a minimum of equipment and effort—a technique which the visiting nurses have worked out to a fine science. This would seem to be a foresighted preparation for any emergency.

In addition, all public health nurses can make themselves ready to take on these new responsibilities by keeping up to date—through institutes, meetings, and the professional literature—on the nursing problems which they may have to meet in care of patients in the home.

P. P.

Two long awaited publications are now ready for distribution. "Posture and Nursing," a blue covered, illustrated handbook, is the first of a series in relation to orthopedic nursing prepared by the Joint Orthopedic Nursing Advisory Service of the N.O.P.H.N. and the National League of Nursing Education, which is financed by a grant from the National Foundation for Infantile Paralysis. Single copies are free of charge upon request.

The *Public Health Nursing Curriculum Guide*, a suggested guide for postgraduate programs of study, is a joint project of the National Organization for Public Health Nursing and the United States Public Health Service. Copies are \$2 each. 1790 Broadway, New York, N.Y.

# The Future Commands Our Attention

By GRACE ROSS, R.N.

THE NICEST thing about this report is the opportunity it gives me to thank all who have made my past four years as President such an enjoyable and educational experience. An alert and understanding Board, an efficient and generous staff, and a membership constantly pressing for further development—this is a combination which not only keeps our organization on its toes but assures a future of timely adjustments, continuous growth, and expanding usefulness.

If these were not such serious times, an accounting of the state of our organization during the past two years would be in order. However, PUBLIC HEALTH NURSING magazine presents our "state" each month, so that our membership is at all times aware of our problems and of our steady progress. Also, our general director, Ruth Houlton, will give her interesting report during this session. And these should suffice. Instead, let us think about our responsibilities of the present and of the future just ahead.

It is easy to settle a problem by doing the dramatic thing, which everyone else is doing—especially when this is heralded and generally approved. It takes courage, thoughtful decision, and tenacity, to keep on doing the *same thing* because that service is what we can do best for the ultimate good of all. We are glad that it is possible for public health nurses to make an extra contribution to war effort even though we stay at our posts. In fact, we could solve many of the nursing problems brought on by this war if every public health nurse determined to do her duty in regard to them, instead of leaving the

burden of these tasks to volunteer committees or to other generous nurses. Think what would happen!

We now number over 23,000 public health nurses in the United States. Suppose that each public health nurse did all of the following seven duties just once each year for the duration: recruited one outstanding young woman for a good school of nursing; persuaded one good, inactive, graduate nurse to attend a refresher course and then to take her place in our army of active nurses; convinced one eligible nurse that she belongs in the Red Cross Nursing Service; convinced a capable non-nurse friend that she should sign up with the Volunteer Nurse's Aides; persuaded one citizen to enroll in a first-aid class, and one mother of a family to enroll in a home-nursing class. Is this too much to expect in a twelve-months' period? Can you imagine the result—23,000 students recruited for schools of nursing; 23,000 nurses ready for active service who were not there before; 23,000 more nurses eligible for military service; 23,000 aides to help over-burdened nurses; and 46,000 lay people equipped to serve in their own homes and in their neighborhoods. There might not be fanfare, but there would be gratification and potentially worth-while results directly in line with war effort.

Another definite contribution to the war effort—over and above the fact that public health work has increased in quantity to meet the increased needs in wartime—lies in the quality of work we do throughout the duration. There are those who give their lives; we can do no less than give a consecrated, professional day each workday of the year. This



means that we gladly delegate to others all duties which they can assume; that we stimulate their service; that we appreciate it and take the time to say so. The sharing of responsibility necessitates self-appraisal, of course, and it goes without saying that withered routine is due for a pruning. Another contribution will result if we study our workday so that all waste of time, of distance, of supplies, and all waste due to poor planning or useless effort is eliminated for the duration. Waste of days because of preventable illness should be included also, for keeping fit ourselves is a first responsibility. Our slogan could well be: "Every service must count, and count for the greatest number."

Then there is the matter of the work itself, based upon earnestness, conviction, and desire to share that which is good. Identifying ourselves with the patient and motivating him on the basis of his own interest; convincing others of the value of good health, so that they appreciate it, desire it, and become willing to work toward achieving it for those under their care—this is defense service, also, and of a high order. We can help by lessening the burden of those responsible for our work—many of whom are carrying increased burdens—by leaning on others less, by cultivating self-reliance, and by seeing things through. Also, our own attitude on the job can help win this war. If we engender in others the feeling of security, self-reliance, and a philosophy of ultimate victory, and convey through our sincerity a worth-while in all that we teach, we shall be bolstering up the home front in generous measure.

These points are presented for those who think they would be more useful elsewhere. Any public health nurse who feels that she can measure up to this description can remain where she is without worrying.

It is the future which commands our immediate attention. If we have a definite part to play in the reconstruction period in other parts of the world as well as in our own, many public health nurses should be preparing for it now. In the past, the success of our work depended upon our knowledge of the family and of the community. There is reason to believe that our success in the future will depend upon a greater knowledge and appreciation of our country and of the world, as well. In few instances have nurses taken on community responsibility except as it benefited nurses and nursing. Even though our own work is serious business of importance to the community, we are not released from the civic duties common to all citizens, and it is time we assumed our part in them.

Mental health as well as physical health is our business and yet we have disregarded those social ills which bring about mental illness. We have often helped to save life according to the tenets of our professional creed and yet thought little of those conditions which robbed living of its worth. If our objective in this war means anything, it means that for the first time living shall be democratic living and have more worth; and in the days of practical adjustment to this social change, public health nurses must take their places as public servants. We can be helpful—if we are prepared for the changes to come—largely by helping others to make their adjustments, and by supporting those measures which make available the optimum of healthful living for all—measures for proper housing with sunshine, fresh air, and space for wholesome play; for proper food, available in amount and kind for all. We can be helpful by getting behind measures which will make democracy really work, for as long as mankind lives and works under conditions which have

within them the essence of slavery, even though camouflaged, a program for mental health is an anachronism.

We have a duty toward those who unwittingly cause others to develop slave reactions: to help them recognize these results as such. Our creed "life, liberty, and the pursuit of happiness" is so easily misinterpreted by those who think only in terms of their own interests. Democratic living calls for "life" as fully and democratically possible for each member as for every other member of society, "liberty" which does not encroach upon the freedom of others, and "the pursuit of happiness" which does not deprive others of their happiness. Many must be helped to accept the democratic interpretation of these words. A democratic society calls for a set of new values, a new measuring stick for community worth. And again

it will be accepted with difficulty by some. We can assist by showing a greater respect for all who serve the community and by dignifying the service of the least who gives his best.

Heretofore, too many of us have been content with fulfilling the professional obligations of the nursing world. In the future, we will be challenged to meet the full obligations of citizenship in a more nearly liberated world. We are confident that community nursing, in its largest sense, will add more and more to the happiness of living. In the conviction of the dignity and worth of every citizen from the highest to the lowest, we shall with quickened step continue on our way.

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Presented before the N.O.P.H.N. Business Meeting, Biennial Convention, Chicago, Illinois, May 19, 1942.

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## CHARTER FOR CHILDREN

**T**HE Children's Bureau Commission on Children in Wartime, including 56 members appointed by Katharine F. Lenroot, chief of the Children's Bureau of the United States Department of Labor, met in Washington, D. C., March 16 to 18, 1942.

At the close of its discussion the commission adopted three resolutions and a report which included a charter for children in wartime and a program of action to meet the wartime needs of children in the United States grouped under the following objectives:

1. Guard children from injury in danger zones.
2. Protect children from neglect, exploitation, and undue strain in defense areas.

3. Strengthen the home life of children whose parents are mobilized for war or war production.

4. Conserve, equip, and free children of every race and creed to take their part in democracy.

The Commission elected as its chairman Leonard Mayo, dean of the School of Applied Social Services, Western Reserve University, Cleveland, Ohio, and president, Child Welfare League of America, and authorized him to appoint an executive committee to carry on the work of the Commission between meetings. The chairman, as authorized, appointed the executive committee on March 18, including the chairmen of standing committees advisory to the Children's Bureau.

# Co-Workers with FSA Families

By ERNA E. PROCTOR

**Health and self-sufficiency for the most economically and educationally underprivileged group of farm families are made possible through this coöperative program**

**T**HE public health nurse and the home management supervisor are natural allies in work with Farm Security Administration families. Who are these families and what is their need?

They are a group, perhaps half a million of them, who for many years have been on the down grade from the standpoint of agricultural income, satisfactory homes, and general health. It will be recalled that approximately a million farm families were on relief rolls in the United States in 1933-1934. The environmental factors which contributed to their dependency focused the attention of the nation on the need for an educational program that would help them understand the forces which so strongly influenced their lives and gradually become able to cope with them.

The rural rehabilitation program was established under the old Federal Emergency Relief Administration, which endeavored to make it possible for these needy and destitute farm families to become self-supporting, independent, self-respecting citizens, confident of their ability to take care of themselves. In time the rural rehabilitation program developed into the Farm Security Administration in the U. S. Department of Agriculture. But the objective remained the same—to make these low-income farmers self-supporting, independent citizens, who because they are sharing in the benefits of our democracy, have a stake in it; and because

they have been given certain opportunities, can now see their way into a richer, fuller life.

As time has passed, the many inter-related economic and social problems which entered into the environment of these families have brought clearly into focus the need for certain curative work which must be done with them before their rehabilitation can be accomplished. The Administration has been alert to all these problems and has set up many services to meet the needs of the families. One of these services or divisions has been known as Resettlement Projects, a program through which houses have been built, barns constructed, fields improved, fences built, better farm and home management practices established, and community services provided—among them health centers with public health nurses, known as community nurses, in charge of the health programs.

From the beginning, problems in farm and home management were recognized, and personnel were employed to begin the education of the families to the end that more efficient farming and homemaking might be possible. Trained home economists, later known as home supervisors, were employed to carry on a program of education in home and family life.

When public health nurses were employed, it was recognized that they and the home supervisors were laborers in a common field. Together they consti-

A baby in a Migratory Labor Camp—comfortable in a homemade crib—is visited by the FSA community nurse



*Courtesy, Farm Security Administration*

tuted a "natural" in the Farm Security Administration effort and they have demonstrated the effectiveness of a closely coordinated program.

The home supervisor, in developing a home plan with a family based on its needs and ability to meet these needs, uncovers problems which bring the nurse into the situation as a co-worker with her and the family. The nurse in turn constantly brings to the surface, in her visits and conferences with families, problems with which the home supervisor can assist the family.

#### WHO ARE THE FSA FAMILIES?

Let us look at a few of the problems facing the low-income farm families under the supervision of the Farm Security Administration. Studies show that half of all FSA borrowers, who are typical low-income people, have never gone beyond the seventh grade, and the average borrower has only a fourth-grade education. In the South, my sec-

tion of the country, two out of three of the farmers on the FSA program have never completed more than the seventh grade. Without educational assistance and guidance, these farmers cannot and will not participate fully in the activities of their communities so that they feel a real part of it. These are people without adequate opportunities for self-development, without adequate training to do a good job of balanced farming, and without an adequate share of the nation's education and resources.

Genetically, they are not inferior. I have heard Vice-President Wallace say that environment and limited experience rather than heredity have contributed to their plight.

Happily, more people generally are coming to see this fact, to see the cause and the effect, and to hold up the hands of agencies which seek to do something about conditions. The following letter from a school principal, dated April 11,

1942, was addressed to the Farm Security home supervisor in a county in Georgia.

Some years ago I resolved to determine why some children in school were so dull and showed such a lack of interest in their work as compared to others. As their teacher, I was greatly concerned. I was inclined to be "hard-boiled" with them and make them get it. I believed them to be purely lazy. After these methods failed, I systematically analyzed each child's case. I visited his home, spent a lot of time in conversation with his parents, and studied his environment. Well, after my visits were over and each child's case was analyzed, I came to this conclusion:

I saw that what they needed was a lot of sympathy and understanding. For in their homes were found foods not sufficient for their bodies to work and grow; beds not of the type to produce a rested, relaxed body the following day; lights too poor for anyone's eyes; clothing inadequate to keep their little bodies warm; poorly heated homes.

I could mention many other things contributing to their indifference; however, I feel that I have named enough to justify the statement that I was a converted teacher—one who, I hope, is sympathetic and understanding.

I am so happy to say that we do not find the indifference and failures now as before. I firmly believe that the dawn of a new day for our underprivileged children was brought about through the Farm Security Administration. I go to these same homes. I see the better conditions that prevail. I hear them talk of their home supervisor's visit. I hear them say that you told mama this or that about the garden, about canning, about their clothes.

Mrs. —, I felt that I wanted to express my appreciation to you as one who is doing a great work and bringing much happiness and help to a group which I know need it. Much success to you!

I once heard a well known scientist say: "Give me a couple, man and wife, of the well-to-do, privileged class, well nourished, well educated, and accustomed to the good things of life. Put them in an isolated, backwoods, badly eroded section; remove schools; confine them to a tenure system which makes them wanderers on the face of the earth always in search of something better,

without friends, without credit, with inadequate land resources, and with very limited food supplies; and in a few generations, I will show you a family of so-called poor white trash."

The incomes that these families eke out are too small to support the purchase of operating goods for the farm and the home and to buy the services, such as medical and dental care, which the families need.

#### HEALTH PROBLEMS ARE BASIC

These families are often poorly fed, poorly housed, poorly clothed, and without any sanitary facilities which protect them from diseases resulting from inadequate sanitation. The resulting poor health stands as a barrier to the full realization of their productive and earning possibilities. You, of course, know that poor health among low-income farm people is widespread. In 21 typical counties in 17 states, thorough physical examinations were given in 1940 to 11,497 people, FSA borrowers and their families. An average of more than 3½ physical defects was found for every man, woman, and child. Poor teeth comprised the most common defect. Malnutrition was found in about one in every 10 children under 15 years of age.

Most families had accumulated defects over the years as a result of inadequate medical and dental care. For example, 54 percent of the wives in white families were suffering from childbirth injuries; 8.5 percent of the heads of families had hernias; 60.5 percent of all children had diseased tonsils.

It is impossible for a sick farmer to do a good job of production. It is improbable that a woman with old lacerations or with a mouth full of decayed teeth and diseased gums can be an efficient homemaker for her husband and children and carry on the jobs essential to satisfactory home life.

The rehabilitation of families is de-



pendent in a large measure on the kind of farm- and home-planning and operation the family can carry on, and this ability is highly conditioned by the health of the family. A first goal of rehabilitation is to make the family free to work out its own salvation.

This freeing comes first through removing the handicaps caused by inadequate nutrition. Provision is made by the family, in every farm and home plan, for the production and preservation of enough good food to supply an adequate diet the year round for the entire family and for visiting city kinsfolk.

Provision is made for the improvement of sanitary facilities, screens, water supplies, bedding, and other farm and home equipment, which makes for better health. Better housing, with room for privacy for the various family members, is available to each family on the projects. Through group effort and pooling of resources, medical and dental care and hospitalization are provided. Disabilities such as hernias, dental caries, diseased tonsils, adenoids, and other physical handicaps must be removed. Reparative work must be done on old lacerations. The whole family must be given inoculations which will protect them against certain preventable diseases. Clinics must be held for ridding individuals of venereal diseases. Well baby conferences must be established and attended by mothers with their children.

#### FIRST EDUCATIONAL TASK

Instruction must be given concerning the importance of adequate diet, and the people must be taught how to produce, plan, and prepare the right kind of food. This instruction must be given so as to stimulate them to want to eat the right kind of food prepared in the right way. This means changing long established and sometimes racial food habits—a tedious teaching job.

These are the families who are underprivileged as to education and experience, that is, formal school education and education in how to live and how to make a living. They have little appreciation for abounding good health. Never having had it, they don't know how it feels and therefore they lack an impelling desire to have it. They have had little or no experience with adequate diets, with clinics, with doctors, nurses, and dentists, and what these may mean to them.

And so the need for the public health nurse and the home management supervisor becomes apparent. The contribution that each can make, and their relationship and responsibility for the education of these families are evident.

Loans and grants with which to purchase the facilities for making a living and producing and conserving their food are available to every family. Clinics are provided for immunizations and treatments. Sanitary facilities are made available but the families must be taught to appreciate and use them. An immense effort must be made to guide these people to take advantage of the opportunities offered them and to want a better, more satisfying way of life. Here the nurse and the home management supervisor meet on common ground. Here they pool their knowledges, their teaching skills, their individual technical and professional approaches to this big job.

The home management supervisor's job is to develop with the family, on the level of its ability and the productive capacity of the farm on which it lives, a homemaking program which will gradually enable it to build a more satisfactory home life; a richer, fuller experience through securing by its own efforts, healthier bodies, more comfortable and attractive homes, more adequate home furnishings and equipment, suitable clothing, and a fuller participation in the activities of the commu-

nity. The nurse steps up the tempo of this program through her work.

#### HEALTH IMPROVEMENT FIRST STEP

A large part of the solution of the problem lies in the improvement of the health of the family. Malnourished, malarial, or hookworm ridden men, women, and children are lifeless, indolent, and often negativistic. Malnutrition can be overcome to a large extent by a program of adequate food production, preservation, preparation, and consumption. The home supervisor is the logical teacher in this field.

The nurse, through her visits with the families, reinforces the home supervisor's teaching. She emphasizes the importance of proper feeding. She overcomes some of the resistance of mothers and children to new foods prepared in new ways. If special diets are needed, she consults with the home supervisor, who in turn teaches the homemaker how to secure the foods through production and how to prepare them for use. If purées are needed or if a canning budget for the special diet is desired, the home supervisor teaches the family how to do the job. She sets the standard for the amount of food to be produced and conserved in order that the family may have a year-round adequate diet. She guides the family in making better plans and providing better facilities for serving food. She educates the mother in methods of developing good food habits in the family. She assists the family in acquiring an appreciation of its need for the right kind of food, its resources and ability to meet these needs.

Here the nurse enters the field. It is her job to teach families, through home visits or health-center conferences, concerning the prevention of disease, the relation of nutrition and good food habits to health, and the promotion of positive physical and mental health. Her work is a natural complement to that of the home supervisor.

The home supervisor, in developing home plans with families, may find that there is a woeful lack of appreciation of the proper care and use of screens, a sanitary water supply, and sanitary privies. She attacks the problem from the standpoint of management of the home—management that is conducive to comfort and health. The nurse explains the reasons why control of flies and mosquitoes is important. While she teaches the mother how to care for ill patients, she is supplementing the teaching of the home supervisor concerning management problems. She, along with the home supervisor, tends to overcome the apathy and ignorance of the family. Together they develop in the family a felt need for improvement.

The nurse while giving bedside care to a sick patient or a mother and baby trains some member of the family to carry out simple home-nursing procedures. The home supervisor supplements this teaching by assisting the family to set up home routines which make it possible for the ill one to be cared for while the regular homemaking jobs are being carried on.

#### HEALTH COMMITTEES FORMED

On each project, neighborhood groups of women have been organized for the purpose of promoting interest and full participation in all community activities and of teaching special skills in all areas of homemaking. A health committee for the whole project grows from these neighborhood groups of eight to ten women because each neighborhood group appoints one of its group to membership on the health committee. This committee is the right arm of the nurse. Its members are leavening agents of health information for their individual neighborhood groups. They assist with all health center activities, promote attendance of mothers at child health conferences, immunization clinics, and other types of clinics.

Instruction to women and girls in making any type of clothing which they may need in order to carry out the recommendations of the nurse for layettes, maternity dresses, clothing for the sick becomes the home supervisor's job.

While the nurse is technically responsible for coordinating all aspects of the general health program, including the medical care plan, the environmental sanitation program, and instruction in home hygiene and safety, she and the home supervisor work closely together in all these fields. When the family makes up its budget for cash living expenses for the year, the home supervisor must give assistance in setting up funds for the various items in the budget, such as medical and dental care; drugs that may be needed—for example, quinine in a malarial section; clothing for the expectant mother and her baby; furnishings and equipment for the sick-room; first-aid equipment.

Safety in the home is important. The nurse teaches the family safety measures. The home supervisor may teach them in group meetings how to make and use safety devices in the home.

#### HOW WE WORK TOGETHER

Let us look at a few specific jobs which call for cooperative effort, observing the areas in which each functions.

The nurse teaches the family measures for the control of communicable diseases. The home supervisor may teach the homemaker how to organize the home work and household so as to carry out the nurse's instructions. In venereal disease control and treatment, the home supervisor may assist the nurse in building morale and in developing in the family a feeling of need for the control. She may assist the nurse in getting cooperation from the family. Where family relationships are involved the home supervisor may guide the family to fuller cooperation.

The nurse promotes the school health program but the home supervisor guides the family in making it possible for the children to carry on health habits in the home and to participate fully in all phases of the school health program, including school lunches.

Home hygiene can hardly be separated into what is the nurse's job and what is the home supervisor's work. For example, care of the water supply to control waterborne diseases; care of the family cow and production of clean, safe milk, care of milk in the home; sewage and waste disposal; exclusion of mosquitoes and flies from the house through proper care and use of the screens; control of rats, roaches, fleas, mites, bed-bugs, lice, and ants—these are all home-management jobs which must be carried on if the family is to live in comfort, safety, and health. The nurse is vitally interested in the whole home-hygiene problem. She has the technical information. The home supervisor guides the housewife in organizing the housework and carrying on the cleaning and other protective operations which may be recommended by the nurse. The two meet with neighborhood groups jointly and discuss measures and procedures with the women. The health committee may organize a spring housecleaning campaign for the whole project. This committee may sponsor Child Health Day, Health Week, or what not, following discussion in group meetings in which both nurse and home supervisor have participated.

Our reports show many specific examples of this cooperative activity. A woman with several small children was suffering from high blood pressure. A definite schedule of diet and work had to be worked out for her. The nurse and home supervisor together did the job. The care of the tuberculous in the home, prenatal care, baby feeding, food habits of the toddler, family relationship

difficulties growing out of the menopause, miscarriages, excessive field work for pregnant women, care of pellagra patients, preparation of canning budgets for patients with gastric ulcer or canning budgets for babies—all these and many more problems form the basis for co-operative educational work of the nurse and the home supervisor.

#### EXHIBITS JOINTLY PREPARED

On one project, their coöperative effort led to the setting up of an exhibit showing the health activities being carried on by the families under their supervision. An ever-ready pantry was shown. It was filled with fruits and vegetables adequate to meet the year's needs of the family—canned meat; dried and stored beans, peas, potatoes, nuts, and peanuts; cured smoked hams, side meat, and lard; corn and wheat for bread; and homemade cheese. On a table with the wheat was placed a hand-mill used by the homemaker to grind whole wheat flour and to crack grain for cereal. Bread made from the whole wheat flour was shown. Posters suggested special diets to be made from the family food supply.

On another table was equipment for the new baby: a baby's bed with a homemade mattress; covered mayonnaise jars for nipples, swabs, and other supplies; a sardine can for a soap dish; and a medicine cabinet made from an orange crate. All this equipment had been made by the women and painted in group meetings under the instruction of the home supervisor and the nurse. Posters around the booth gave suggestions for the spring campaign against diseases and the importance of protection against diphtheria and typhoid fever.

A lawn party was given at one school to raise money for the crippled children's fund. The home supervisor assisted in planning and preparing re-

freshments while the nurse served as one of the hostesses.

The mother of two orthopedic patients failed to follow the diet plan suggested for the children by the clinic. She said: "The children do not like the foods on the diet list. I have so much trouble getting them to eat anything besides bread, syrup, and meat." The nurse and the home supervisor joined hands in convincing the mother that the diet was important; that the children must have milk, leafy vegetables, and plenty of sunshine; and that it was her job to encourage them to acquire new food habits. The home supervisor assisted the mother to learn attractive ways for preparing the food; the nurse complimented her on the progress being made and kept a watchful eye on the children so that she could call the mother's attention to their progress or lack of progress.

#### CONSTANT GUIDANCE IS NEEDED

The home supervisor and the nurse realize fully that it is not enough to arouse within a family a desire for a better and more satisfying home life. Both appreciate their role in teaching families how to attain a better standard and that this means constant supervision, guidance, patience, resourcefulness, and understanding. They also realize that together they are much stronger than either is individually.

The home supervisor is a graduate of an accredited school of home economics. Because of her training, she is able to carry on an educational program with families. First, she must become thoroughly familiar with the abilities, appreciations, and understandings of the family. Then she must plan her program so that the family may be able to understand the goals and objectives. She must guide the families to set goals for themselves; and she must teach them how to attain these goals. She must be

sure that the goals and objectives which she is setting with the families are consistent with those set by other workers on the project.

The FSA community nurse\* is a graduate of an accredited school of nursing, with public health nursing preparation and experience. At the present time, there are 46 nurses on duty in community type projects and 65 nurses in the labor camp programs. Each group of labor camps has a supervising nurse serving the nurses in its camps. Regional supervising nurses are employed in the three regions which have community nursing programs. The national supervising nurse, attached to the Chief Medical Officer's staff in Washington, has prepared a community nursing service handbook for the guidance of all the community nurses.

The FSA nurse uses family folders. Her activities report code corresponds to the one used by the U. S. Public Health Service. A standard community nursing service uniform, navy blue in color, has been adopted. The nurses use the standard-type visiting nursing bag, fully equipped, and a standard-type leather, zippered envelope case for carrying records and other materials.

The nursing program is carried out with the coöperation of the state health department, local health officials, practicing physicians and dentists in the area, and community agencies such as the school board and the welfare department. Although the field medical officer or the supervising nurse assists in making the first approach to key professional persons and agencies, the community nurse is almost entirely responsible for promoting a good working relationship with such individuals and agencies in her area, and in general, the

project nurses have been able to work in close coöperation with them.

I may have implied that the home supervisor and the nurse are the sole workers in the job of promoting the health of families on the projects. However, they work closely with the community manager and his other aides. In fact, the administration of the community project determines in a large measure the effectiveness of the work of the nurse and the home supervisor.

We believe that the families with whom our nurses and home supervisors have been working are approaching a realization of our objectives. Through the removal of physical defects and other reparative work, individuals have been freed from handicapping conditions. The food production, preservation, and preparation programs have made nutritious diets available and the families have learned to like them. A sanitized environment has made it possible for the people to be relieved of the deadening influence of malaria, hookworm, and typhoid fever. In short, the joint activity of the community nurse and home supervisor, with the assistance of other workers, has resulted in men and women capable of carrying on a full-time job of progressive farming and homemaking. Fewer man days and hours are lost since the people are better nourished and comparatively free from fatigue because of increasing health and strength.

Their glory can be expressed in the words of Emerson: "The glory of the farmer is that, in the division of labors, it is his part to create. All trade rests at last on his primitive activity. He stands close to nature; he obtains from the earth the bread and the meat. The food which was not, he causes to be."\*

We believe we are on our way to attaining the goal set by Emerson when he

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\* The public health nursing program of the Farm Security Administration was described in an article, "Community Nursing—FSA Style," by Matilda Ann Wade, in *PUBLIC HEALTH NURSING*, February 1942, page 82.

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\*From the essay, "Farming," by Ralph Waldo Emerson.



said: "We owe to man higher succors than food and fire. We owe to man man. If he is sick, is unable, is mean-spirited and odious, it is because there is so much of his nature which is unlawfully withholden from him. . . . You are to bring with you that spirit which is understanding, health and self-help."\*

This the co-workers, home supervisor and nurse, are doing.

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\*From the essay, "Domestic Life," by Ralph Waldo Emerson.

Presented before the N.O.P.H.N. general session on Nutrition and Health, Biennial Convention, Chicago, Illinois, May 21, 1942.

## Refresher Classes for Inactive Nurses

By BERYL LUSSOW, R.N., AND MARY BURKE, R.N.

A REFRESHER series of classes was offered in 1941 by the Nursing Division of the Detroit Department of Health to former staff members to prepare them for return to the Department in case of emergency.

Six nurses took the classes when they were first offered in June 1941 and four enrolled when the series was repeated in September. Since many of the nurses found it difficult or impossible to get help for the care of their small children, or to arrange for family responsibilities satisfactorily, the number that responded was smaller than anticipated. Eighteen classes were held in all, three times a week, for two-hour periods.

Over half of the nurses who attended the classes are now working in the Department or are to be appointed to regular staff positions. Upon return to the staff, the nurses are either assigned directly in the field or placed in the teaching center for more detailed instruction, depending upon the amount of generalized nursing they have done, and upon the recency of their experience.

The series of classes was planned mainly to give an overview of the changes in scientific knowledge and in

procedures that have taken place during the past few years. Demonstrations of techniques were not given. The details of care necessary in specific situations were left to be taught if and when the nurses returned to active duty. Emphasis was laid on development of review material that would be meaningful and stimulating to the group.

The plans for the content and method of teaching were based upon two premises. First, we believed that a nurse is never really retired from nursing, since people turn to her for advice or she is asked to give care to relatives. We assumed that there would be areas in which the nurses would be up to date from talking with friends who were active in nursing, and from passing this information on to others. Nor were we disappointed. All the nurses had a great deal of information to offer regarding pediatric practices from comparing notes with their friends. All were familiar with many of the newer drugs from having used them.

A second premise was that we all carry the impedimenta of past situations, and that in order to help the nurses dissociate the old practices from the new we would have to talk about

both old and new. We therefore organized our class materials around a pattern of what was old and what was new in venereal diseases, acute communicable diseases, school health services, and other subjects.

The nurses in the course commented

upon the speed with which the classes brought them up to date, and upon their enjoyment of the series. The material was then used as a review for the nursing staff.

The content given on venereal disease control is outlined here:

## CHANGES IN THE VENEREAL DISEASE CONTROL PROGRAM

### Control of Syphilis

#### *Old*

Short courses of treatment were formerly given with many rest periods of 2 to 3 months between the courses of treatment.

Mercury rubs were employed in the treatment of children with syphilis.

Spinal fluid tests were done infrequently and were resorted to only when the patient presented clinical manifestations of neurosyphilis.

Neocarsphenamine was the arsenical preparation most frequently used.

Tryparsamide was used in the treatment of neurosyphilis.

Babies born of syphilitic mothers were examined for syphilis at 6 weeks of age.

#### *New*

Eighteen months' treatment without a rest period is advocated for early cases. The treatment consists of alternating courses of arsenicals and heavy metals in a continuous schedule.

The 5-day intensive treatment was instituted under the supervision of the director of social hygiene, Detroit Department of Health, at one of the city hospitals, in the fall of 1939.

Since July 1940, about 5 patients a week have been treated by this method in another city hospital.

The use of mercury rubs has been almost entirely replaced by a course of treatment similar to that used for adults.

Spinal fluid tests are recommended and strongly urged for *all* patients, both children and adults, to be done *early* in the course of the disease since it is now believed that involvement of the brain and nervous system occurs early.

The older arsenical preparation is still used, but a new arsenical preparation, mapharsen, a concentrated drug which is less toxic is used.

Tryparsamide is still used, but alvarsone is supplanting it for some cases. An eye examination is made prior to its use and during the course of treatment, just as in the use of tryparsamide. Optic atrophy is experienced less frequently when alvarsone is used.

Babies born of syphilitic mothers are examined at 3 weeks of age. The rest of the schedule for examination remains the same—6 weeks, 3 months, 6 months, and 1 year. A yearly Kahn test throughout childhood is advised.

### Control of Gonorrhea

Potassium permanganate ( $\text{KMnO}_4$ ) solution was usually prescribed for vaginal douches for both women and children.

Vinegar douches have been substituted for potassium permanganate.

Douches for children have almost been eliminated. Sitz baths are advised when the

*Old*

A large variety of drugs were formerly used to treat gonorrhea.

Formerly some young girls with gonorrhea were hospitalized at a sanatorium in Kalamazoo for a year or more. Others were hospitalized in Ann Arbor, under the Afflicted Children's Act, at \$36 a week.

In 1935, a boarding home for girls with gonorrhea, from 6 months to 10 years of age, was opened in Detroit. It was operated by a graduate nurse under the supervision of the Department of Health, which placed children there when adequate care could not be arranged at home. The boarding home received around \$12.25 a week for each child.

#### Quarantine Unit

Women were first hospitalized at one of the city hospitals. Many of them left without permission, until a unit was opened where they could be detained.

In 1932, the patients were divided. The young women who presented possibilities for rapid social rehabilitation were hospitalized in a small annex to the hospital, in another part of town, while the troublesome ones were detained in the old unit.

In 1934, through the efforts of the director of the College Women's Volunteer Service, an occupational therapist was secured and placed on the Department of Health payroll. The medical director believed that if the patients could be kept busy in a constructive way they would not cause trouble or try to leave. His belief proved correct.

#### Drugs for Treatment

When the first Department of Health clinic was opened to treat patients with venereal diseases in 1916, the patients came in the evening and had to buy their own drugs. In

*New*

discharge is profuse. For slight discharge, a careful cleansing of the genitalia is recommended.

The use of the sulfonamide drugs, particularly sulfathiazole, in the treatment of gonorrhea has completely changed the method and length of treatment. These drugs are given to men, women, and children. They are an effective form of treatment. In children the average length of treatment has been reduced from several months to a few weeks. Studies made during the summer of 1938 at Children's Hospital of Michigan showed that the hospital stay for gonorrheal ophthalmia was reduced from an average of 28.5 days to 5.8 days by the use of sulfanilamide.

Since the use of sulfonamide drugs enables children to get well in a few weeks, they are being cared for in their own homes, and the boarding home was closed this year.

In July 1940, the annex was closed to effect an economy, and a 50-bed unit was opened at the city hospital. Both men and women with gonorrhea or infectious syphilis may be hospitalized there.

The occupational therapy work is still operating with a great deal of success. The art goods which the patients make are sold throughout the year and the proceeds used to buy more materials.

Since December 1937, arsenicals and heavy metals have been made available, free of charge, to private physicians, for the care of indigent patients. The drugs are furnished

*Old*

a short time the Department of Health began buying the drugs for the patients.

*New*

by the State Department of Health. Since May 1941, the sulfonamide drugs have been made available to private physicians for the treatment of gonorrhea.

**Participation of Private Physicians**

In May 1933, an area on the east side was set aside for an experiment in a coöperative plan with the doctors. All medically indigent patients with syphilis were treated by the private physicians living in that area. Drugs were furnished by the Department of Health, and laboratory service was also furnished upon request.

A nurse was assigned to that area. She interviewed each doctor every two months, checking drugs and records. Consultation with the director of the clinic regarding any patient was available at all times.

This plan is still in operation, and in 1941 about 350 patients in this area were being cared for by 50 coöperating doctors.

**Tabulation of Venereal Disease Statistics**

Statistics concerning venereal disease cases were assembled by the Detroit Department of Health and sent to the State Department of Health at Lansing.

In January 1940, the Social Hygiene Division of the Department of Health joined the Chicago branch of the United States Public Health Service tabulating system. The Central Tabulating Unit in Chicago was set up by the U. S. Public Health Service for the collection and standardization of data regarding venereal diseases.

The Central Tabulating Unit assigns the figures to their proper categories and makes up periodical reports for the Department of Health.

**Nursing Service**

Individual conference work with patients was formerly largely done by one nurse.

The clinic gave information to the field nurse only in regard to the patient she inquired about.

Individual conference work with patients is carried on by several nurses, and all the clinical staff are prepared to do it.

Three nurses do intensive case-finding work.

When the nurse inquires about a patient, the clinic assembles information concerning the entire family and sends it to the nurse on a permanent record. This makes it possible for the nurse to evaluate the situation of the entire family and its need for further service from her.

Generalized nurses are participating more actively in the work of locating contacts and of finding patients who are active cases of venereal disease.

# Body Mechanics in Pregnancy

By JOHN G. KUHNS, M.D.

**Causes, symptoms, prevention, and treatment of disturbances in mechanical alignment of the body during and after pregnancy are discussed in this article**

**D**ISTURBANCES in the mechanical alignment of the body during pregnancy are common. This mechanical alignment of the various parts of the body and their efficient working against the force of gravity have come to bear the name of "body mechanics." In the past the application of body mechanics has been directed chiefly to the efficiency of workmen in industries, and of fighting men. It has concerned itself chiefly with the prevention and correction of disabilities of the low back and of the feet since these are the two parts of the body in which symptoms and disabilities commonly appear when the body is used in a wrong mechanical manner. More recently attention has been given to posture and to allied static disturbances in school children with the intent of preventing and avoiding disabilities in adult life through early correction of faulty body mechanics. But little or no attempt has been made to prevent static disturbances and their accompanying disabilities during and following pregnancy. It is more for the purpose of stating the problem of body mechanics during pregnancy and of bringing it into the open, than for the purpose of offering a complete solution of it, that this article is written.

After the beginning of pregnancy many important changes take place in the female organism. These changes can be grouped into two main categories: metabolic and anatomic. The metabolic changes take place for the

purpose of nourishing the mother and the growing fetus as economically as possible. They lead to changes in the circulation, in the endocrine glands, and in many other organs. The anatomic changes occur in order to make room for the enlarging uterus, and in later pregnancy, for easier parturition. We shall concern ourselves only with the anatomic changes in their relation to the maintenance of good body mechanics.

## CAUSES OF DISTURBANCES

Many of the disturbances which arise from faulty body mechanics during pregnancy are simply an aggravation of disturbances which have been present since girlhood and which have required only the extra burden and change in alignment incident to pregnancy to bring on troublesome symptoms. There are, of course, other disturbances which are caused directly by the pregnancy. And still others can be traced to the effects of preceding pregnancies often repeated and inadequately supervised.

It would be best to begin with some tangible concept of what we mean by good body mechanics and then show how this is altered and leads to symptoms in pregnancy. Good body mechanics is the efficient balancing of the body in action against the forces of gravity. (Fig. 1.) We say it is present when there is no increase in the curves of the spine; when the greatest circumference of the body is at the ninth rib; when the chest is used habitually in a position midway be-



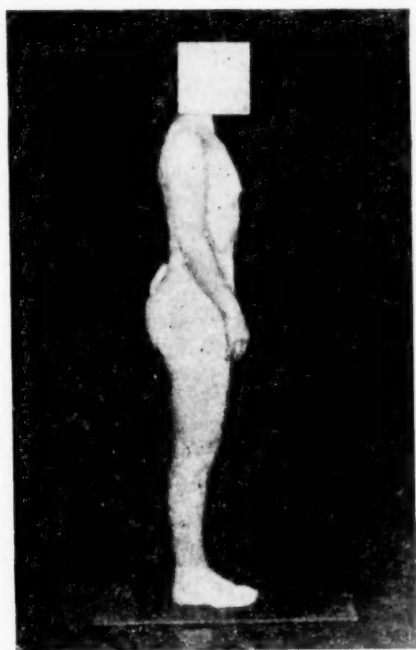


Figure 1  
Fairly good body alignment in early pregnancy

tween full inspiration and full expiration; when the upper abdomen is full and rounded and the lower abdomen is flat; and when the alignment of the legs and feet is best for weight-bearing, with no rolling inward of the mid-foot, no great depression of the arch, and no marked eversion of the forefoot.

In pregnancy the most obvious change is an enlargement of the abdomen with forward projection, and with compensatory lordosis of the lumbar spine. With this there is, as pregnancy advances, a relaxation of the ligamentous structures seen most easily at the symphysis pubis and at the sacro-iliac joints. The enlargement of the uterus is more marked in the multipara, with greater sagging downward and forward of the lower abdomen. All these changes increase with pregnancy. (Fig. 2.)

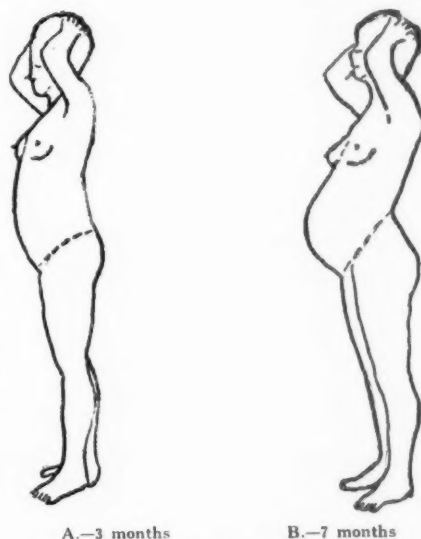
In the later months of pregnancy the enlarging uterus presses upon the upper abdominal viscera and the diaphragm, forcing them upward. Because of the

ligamentous relaxation and the increase in weight, averaging about 20 pounds, and the changed alignment in the legs, disabilities and pain in the feet and circulatory disturbances in the legs are common unless attention is paid to these in the antepartum care.

While pregnancy is a normal process, the border line between health and disease is less clearly marked than at other times and this is equally true of disturbances in body mechanics. Consequently, one should take a common-sense point of view and consider only those aberrations from good body mechanics which result in symptoms. While it would be desirable to correct the minor faults in the body also, this is manifestly impossible.

#### SYMPTOMS THAT OCCUR

The symptom which occurs most frequently is pain in the low back. In early pregnancy, mild discomfort and a sense of tiredness in the low back or in the dorsolumbar region are not un-



A.—3 months

B.—7 months

Figure 2

A. Prominence of abdomen, forward tilting of pelvis, and slightly increased curve of lumbar spine at third month of pregnancy. B. Changes in alignment of body at seventh month of pregnancy

common. At first this is not the result of changes in the back but is caused reflexly by circulatory changes, by the beginning displacement of abdominal organs, and by pressure within the abdomen. But this is soon followed by more severe disability. It is due chiefly to ligamentous strain and occurs because the back is being used constantly in a position of increased extension. The weight of the superimposed trunk comes no longer upon the vertebral bodies but upon the posterior muscles and ligaments which now hold the back against the forces of gravity. As these muscles and ligaments become stretched excessively, pain is felt. This pain referred to the back often becomes worse as pregnancy advances and is relieved only by lying down.

Late in pregnancy a troublesome sciatica may occur from strain of the ligamentous structures about the sacroiliac joints. A relaxation of these joints occurs several months before parturition. Strain in the intrascapular region and over the shoulders and neck posteriorly occurs less commonly. Symptoms here arise usually from a compensatory forward bending at the upper back. Rib strains are common after the middle of pregnancy. Pain from these may be felt along the side or at the attachment of the rib to the spine. Strain of the ribs comes with the enlargement of the abdominal cavity and the lateral spread of the upper abdomen. It can cause very distressing symptoms and can make breathing painful. Strains of the ribs are relieved temporarily by strapping or by a binder. When the body has been in good alignment before the onset of pregnancy such rib strains are rarely observed. They come only when the ribs have been allowed to sag down from poor body mechanics.

The feet are more subject to strain during pregnancy than at other times. If there has been a previous mild disability of the feet, such as a pronation

or a spread of the forefoot, symptoms will come with the increasing weight and ligamentous relaxation. In addition, disabilities in the feet can be caused by the pregnancy alone. With the anterior prominence of the abdomen, and the increased curve in the low back, the forward inclination of the pelvis increases. With this there is a rotation of the femora outward. (Fig. 3.) This leads to strain at the knee and ankle. The position assumed in standing tends

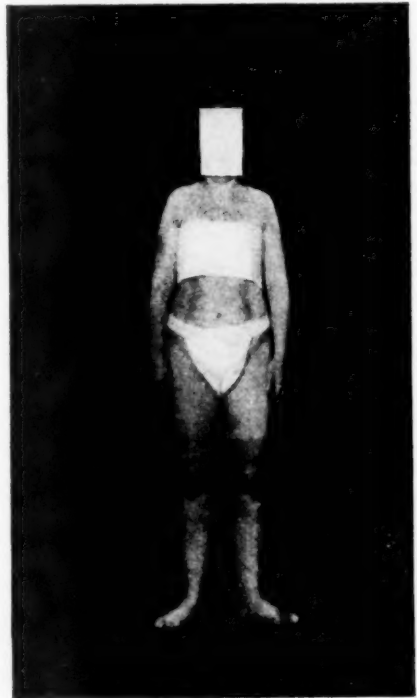


Figure 3

Outward rotation of leg with lowering of arches and pronation in late months of pregnancy

to roll the foot outward and to lower the arches of the feet. The flattening of the longitudinal arch and the common eversion of the foot soon lead to strain on the fore part of the foot with pain and calluses beneath the heads of the metatarsal bones.

Swelling about the ankle is a common accompaniment of foot strain. But swelling in the leg is also observed as the re-

sult of impairment in the venous circulation. This has been usually considered to be the result of pressure of the uterus upon the iliac veins. Some of this is the inevitable accompaniment of pregnancy but it is much greater in the presence of faulty body mechanics. This strain upon the venous circulation is often the precursor of an inflammatory process in the veins in the puerperium. Where the faulty body mechanics persists after pregnancy, varicosities in the veins of the lower extremities frequently develop.

#### PREVENTION BEGINS EARLY

What should be our attack on these disturbances seen during pregnancy? When possible, some attention should have been given to them in girlhood and early womanhood. We focus much attention upon antepartum care, important as it is, but give too little or no attention to earlier preparation for motherhood. If good body mechanics had been attained before marriage, the individual would go through pregnancy with much less difficulty and discomfort. There would be little or no difficulty with emesis in early pregnancy, for the abdominal organs, which sag greatly in faulty body mechanics and are then disturbed by the enlarging uterus, would not be much disturbed. They would change their position little and consequently would not cause symptoms. The spinal and abdominal muscles, being normally strong and working in coordination to maintain the spine in good alignment, would permit only a slight increase in lordosis, and would be little strained during the course of the pregnancy. Backaches are infrequent in women who have learned to maintain good body mechanics before they became pregnant.

There are many methods of securing good body mechanics. Most clinics use a series of exercises for the large supporting muscles of the trunk in order to

develop coordination of the muscles so that working together they will balance the trunk efficiently over the pelvis. Eventually this easy balancing of the spine becomes a conditioned reflex, as can be seen in any well trained soldier. We advise exercises but we have no quarrel with any method that secures and maintains good body mechanics in a reasonable period of time.

#### FIRST RELIEVE DISCOMFORT

After pregnancy occurs, many of the methods which are used at other times can be used to improve the balance of the body but they must be used more carefully. Mild deformities take on added importance at such times since there is an added strain upon the whole organism. During pregnancy, treatment must be directed primarily to relieving the symptoms which arise from poor body mechanics. After discomfort has been relieved, something can be done to obtain lasting improvement in the general poise of the body. The usual treatment is to apply a pelvic belt or special corset for the strain of the low back and pelvic joints.

Supports or strapping are commonly used at first for the feet. These can be so applied that they maintain the part, temporarily, in good alignment. The best support for the back in pregnancy is a corset which lifts the abdomen up and in, and at the same time holds the back relatively flat. (Fig. 4.) Supports under the arches are the simplest devices to relieve symptoms in the feet. Such supports should be used in combination with exercises so that the feet can eventually be balanced by the patient's own muscles. The return of normal function in both the back and the feet without any permanent support is the aim of treatment.

The vomiting which comes early in pregnancy with displacement of the abdominal organs becomes much less troublesome if improvement occurs in



Figure 4

Support (firm, back-laced corset) holding up abdomen, decreasing forward tilt of pelvis and the hollow in low back

the mechanics of the body, particularly in the position of the abdominal organs. Rest in positions which permit the abdominal organs to assume a more nearly normal position in the abdomen usually relieves the symptoms temporarily. The position which should be taken is one in which the patient lies on the back with a pillow under the knees and another pillow under the dorsal spine. The hands should be placed over or under the head. This position causes the low back to become flatter and also raises the chest and makes more room for the abdominal organs in the abdomen. Lying on the face with a pillow under the abdomen for a half-hour before arising in the morning will frequently prevent the morning nausea. A properly fitted corset will maintain an improved position of the abdominal organs fairly well between the periods of rest in the described positions until

the patient learns to maintain the proper position with her own muscles.

#### EXERCISE DURING PREGNANCY

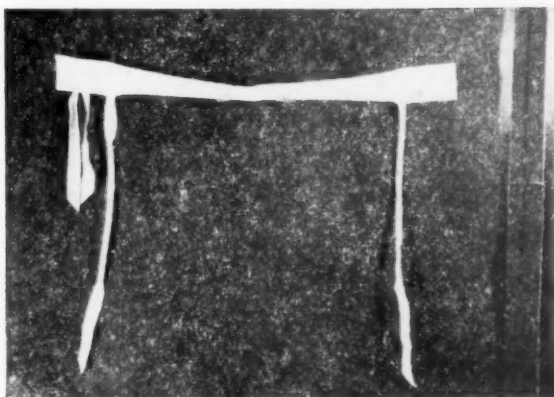
Most obstetricians advise as much exercise during pregnancy as the patient can take without fatigue. The usual activities of the individual should be lessened only as fatigue begins to come on more quickly. Particularly in the early stages of pregnancy, special exercises should be performed in the supine position for flattening the back and raising the chest. Exercises should also be taken in the standing positions to teach the patient good body mechanics. Instruction should be given for proper use of the foot, to carry the weight on the outer side of the foot with the foot pointing directly forward. These should not take more than ten minutes twice a day. As pregnancy advances these exercises should be made less strenuous, and should be performed fewer times.

After delivery, while the patient is in bed, symptoms from bad body mechanics often appear again. The relaxed pelvic joints and the overstretched abdominal muscles cannot maintain the body in good alignment at this time, and strains in the back and pelvic joints occur. For this reason especial care must be taken with the bed in which the patient lies, and with the positions which the patient takes during the puerperium. The bed in which the patient lies should be firm and should not sag. When the patient is partially sitting in bed there should be no bending at the waistline; the back should be flat. The patient will get a great deal of comfort, while lying, from a folded sheet or a small pillow placed under the lumbar spine just above the pelvis. Such support relieves the ache in this region. (Fig. 5.)

An abdominal binder is sometimes given for comfort. It supports the abdominal muscles while the overstretched abdominal wall gradually resumes tone. But a narrow pelvic belt worn snugly

Figure 5

Canvas pelvic belt two inches wide with perineal straps is strapped firmly about pelvis just above greater trochanters



about the pelvis gives the most comfort. (Fig. 6.)

#### POSTPARTUM EXERCISES

There is no definite time for the beginning of exercises after delivery. Special exercises to improve body mechanics can be started as soon as the uterus is well contracted and cannot be felt above the symphysis pubis. These should be of the type designated as breathing exercises. They should not be strenuous. As soon as the lochia have ceased, exercises for the abdominal muscles may be added to retract the lower abdomen and flatten the lumbar spine. These will help greatly in re-

gaining tone in the abdominal muscles as well as in regaining the general strength. Special attention should be paid to the lateral abdominal muscles, which are more important than the recti abdominalis for support of the abdominal organs. After the patient has been ambulatory for several weeks, more vigorous exercises given in the upright position will help to maintain good body mechanics.

#### BELTS AND CORSETS

If no treatment is given for the relaxed abdominal muscles following pregnancy, a relaxation of the abdominal wall frequently occurs, with a paralyzed,

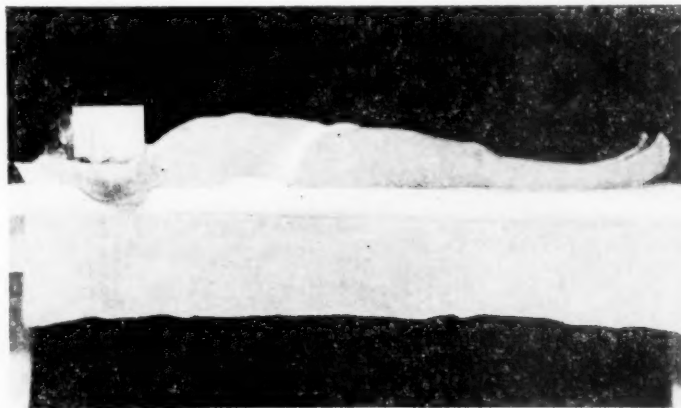


Figure 6

A small pillow under lumbar spine prevents strain of low back during puerperium (A pad under knees and support for feet may also be used for comfort)



pendulous abdomen after succeeding pregnancies. When there is persisting relaxation of the symphysis pubis or of the sacro-iliac joints, a continuation of the pelvic belt of canvas or of leather, worn as tightly as possible about the pelvis, will eventually relieve the condition. Sometimes this must be worn for a number of months. With such a belt, exercises and the daily activities can be carried on with little likelihood of straining the pelvic joints. When no care or support is given to the relaxed pelvic joints, a permanent weakness in this region and backache may result.

Should or should not a special corset be worn following pregnancy? If the patient has been athletic and has good body mechanics, such support is not necessary after abdominal muscular tone has been regained. But most women are more comfortable if the back and abdominal muscles have some support for a number of months after delivery, and if special exercises are performed it does no harm. Here a back-laced corset is usually the most effective support. It gives comfort to the back and at the same time helps to maintain good body mechanics until the patient is able to do this with her own muscles. By such means the tremendous relaxation which so often occurs with suc-

ceeding pregnancies can be prevented.

In summary, we can say that in pregnancy there is an increase in weight, an enlargement of the abdomen, a relaxation of the pelvic joints, a forward tilting of the pelvis, a stretching of the abdominal muscles, and an increase of the anteroposterior curvature of the spine. All of these are inimical to the maintenance of good body mechanics.

The effects which these have upon the alignment of the body are shown by pains and disability most commonly in the low back, the dorsolumbar region, the feet, and occasionally at the ribs.

The best prophylaxis of these conditions is development of good body mechanics as a part of good general health before pregnancy occurs. A few regular exercises, breathing and abdominal, performed daily, with attention to the way that the feet are used, are enough to maintain good body mechanics. Proper shoes should also be worn, preferably Oxfords with low, broad heels. Any foot disability should be corrected before or during early pregnancy.

For treatment of the disturbances during and after pregnancy, rest, the use of a corset, foot supports, and mild exercises are the most effective method of relieving symptoms and preventing their recurrence.

## THE AMERICAN JOURNAL OF NURSING FOR JUNE

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# To Help You Teach Home Nursing

By ANNA C. GRING, R.N.

**T**HE Red Cross Home Nursing Course provides the individual with an opportunity through group thinking and group discussion to learn how to meet his own and his family's health problems more effectively. Specifically the objectives of the course are to increase the individual's knowledge and ability so that he may be able: (1) to maintain his own and his family's health (2) to give safe home nursing care under the guidance of a physician when continuous professional nursing care is either unnecessary or not available (3) to assume responsibility for participation in community health and welfare activities.

At present the minimum period of time in which the course may be given, if the students expect to receive the Red Cross Home Nursing certificate, is 24 hours for adult groups and 30 hours for children.

Three basic types of course are available—the Standard, the Modified, and the Junior Course. The Standard Course is intended for adults whose educational background is comparable to that of the high-school graduate. It may also be adjusted to the needs of students in the eleventh and twelfth grades and to college students. The Modified Course is intended for adults who have a language handicap or a limited amount of formal education. The Junior Course is intended for school-age children. It is *not* intended for children under twelve years of age or below the seventh grade.

The basic reference for all courses is the American Red Cross textbook, *Home Hygiene and Care of the Sick*. A selected list of references which will

both complement and supplement the textbook is recommended so that those people who take the course may have the benefit of the most recent scientific information available.

Obviously the experiences and needs of the individuals comprising the various groups differ widely. In order to meet these needs and to attain the objectives of the course the teacher must have a knowledge of subject matter and an understanding of how individuals learn most effectively, and must do careful planning in advance. In this article the writer will assume that every authorized instructor is familiar not only with the content of the textbook but with current trends in fields such as maternity and child health, nutrition, and communicable disease. (Suggested references may be found in the American Red Cross publications listed at the end.<sup>1</sup>) Therefore the greater part of the article will be devoted to suggestions for helping the instructor plan the course and the presentation.

## MAKE TENTATIVE PLAN

A good beginning increases the instructor's self-confidence and also the confidence of the group. Planning in advance is one of the best ways for assuring a good beginning. Prior to the first class meeting it is desirable that the instructor write out a tentative plan for the whole course. Adaptations and changes will have to be made before and during each class period in order to provide for the needs, interests, and objectives of the students in the group. Fortified with a plan, the instructor will be able to explain the scope of the course to the group to better advantage at the first class meeting, and the group will

participate with greater intelligence if they do understand the scope of the work to be undertaken. It is recommended that the course be planned on a unit basis, using what Jones calls the unit of adaptation.<sup>2</sup> This type of unit is suggested in preference to the subject-matter unit, or the center-of-interest unit, because the objective aimed at is the student's ability to meet specific life situations as they occur. For example, the following may be considered objectives of the Red Cross Home Nursing Course for a group taking the Junior Course:

1. Ability to safeguard personal and family health in normal and emergency conditions.
2. Ability to give safe home-nursing care under the guidance of a physician in minor illnesses.
3. Ability to administer first aid in home emergencies.
4. Ability to use health resources in the local community as needed.
5. Recognition of individual responsibility for maintenance and improvement of and participation in community health and welfare programs.

#### TEACHING UNITS

The number, type, and length of units will depend on the needs, interests, and background of the students and the time limitations of the course the group is taking. Each major or central objective becomes the subject of a unit. And in order to attain the objective each student will have to participate in certain specific, related activities which will help him attain his goal. Thus if the first objective is to be attained the student will have to learn among other things how to select an adequate diet and why it is essential that he do so; what is meant by good posture, and why it is desirable to maintain good posture, whether he is sitting, standing, brushing his teeth, or making his bed; what are the early symptoms of communicable disease, and why and how to isolate himself when he has signs of a communicable disease. He will have to

know, understand, and observe the community safety regulations recommended for normal times and for emergency situations—for example, blackout regulations.

In order to be able to give safe home nursing care he will have to watch the instructor take a temperature, give a bed bath, fill a hot-water bottle, and carry out other simple nursing procedures; and following the demonstration, he must have an opportunity to practice these procedures.

Thus, subject matter becomes a tool and not an end in itself. And the student must actually participate through reading, observing demonstrations, and practicing those activities which relate to his goal.

Included in each unit is the major or central objective; subsidiary or contributory objectives which may be described as parts of the major objective; learning activities, such as reading, demonstrations, and practice; leading questions and discussion points; and a plan for determining to what extent the goal has been attained. Thus each unit may be described as a "group of planned, coordinated activities undertaken by the learner in order to obtain control over a type of life situation."<sup>3</sup>

#### NEEDS DETERMINE COURSE CONTENT

Inevitably the instructor is faced with the problem of deciding what to include, not only in each unit but in the course as a whole. The needs of the group and their probable use of knowledge in life situations determine the content of the course to a large extent. Obviously then, the instructor must understand the background of the group, their interests and reasons for taking the course. Several methods have proved successful.

In the first class period the group may be asked to write the following information on a slip of paper which is to be returned to the instructor: name; address; number and ages of children, if

any; size of home; radio programs to which the family usually listens; magazines read by the family; reason for taking the course. As an alternative, the instructor may ask each person to introduce herself and give similar information verbally.

Or the instructor may plan to have a quiz program in the first class meeting. The questions asked will of course relate to the content of the course to be covered and may include both theory and procedures. This quiz program is usually called a pretest and may be either written or oral. It is used to determine the kind of information and habits the students have in relation to a particular situation. It also helps to interest the student in the unit and indicates to him the kind of work he is about to begin. The oral pretest is probably preferable for the students who take the Home Nursing Course. The questions should of course be suitable in relation to the experience and background of the group to be tested. The following are questions which might be used as part of a pretest or quiz program at the first class meeting of a group eligible for the Junior Course:

1. Do you think it is desirable for you to stay home from school if you are coming down with a cold? Why?
2. What is the normal body temperature of a high-school girl?
3. Can you read a thermometer used for taking body temperature?
4. What is the most desirable room temperature for ordinary purposes?
5. Do you think you should go swimming when you are menstruating? Give reasons for your answer.
6. What will help you to keep your skin free from pimples and other blemishes?
7. How does the kind of food we eat everyday affect pep and enthusiasm?
8. What kinds of food should we plan to include in our daily diet?
9. What kinds of food should we limit?
10. Do you think it is all right to skip breakfast if you manage to eat the necessary foods later in the day? Give reasons for your answer.

The beginning unit of the course is really determined by the request of the majority in any one group. This is a desirable procedure because participation and learning of the group are always more effective when the group select and accept an objective as worthwhile. The content of each unit is determined on the basis of the needs of the group as revealed by the pretest and by later discussion. This means that if the majority in any one group wish to begin with the unit on the care of children, the course should be started at that point. It may be unnecessary to discuss many of the desirable personal health habits, but perhaps more time should be devoted to a discussion of what is meant by an adequate diet and methods of providing an adequate diet on a limited income. (See ARC 725, "Food and Nutrition.") The instructor must thus select and discriminate in regard to the methods employed, the activities suggested, and the content of the course as a whole.

#### DEMONSTRATION AND PRACTICE

Methods of presentation influence the effectiveness of the course to a great extent. Because of the variety of situations and individual differences, a combination of several methods is usually desirable. In teaching Red Cross Home Nursing it is advisable to demonstrate whatever can be demonstrated and give the students an opportunity to participate through practice and discussion. The methods found most effective in teaching this course are demonstration and supervised practice, informal discussion, the use of carefully selected assignments, the use of the summary, and the use of stimulating and thought-provoking questions. Needless to say, the lecture method is usually both ineffective and undesirable in this type of course. Reading during the class period, except to clarify a point under discussion, is usually unprofitable and a

waste of the student's time. Visual aids such as charts and posters are effective when related to the subject under discussion. The blackboard is invaluable regardless of the type of course being studied.

The value of the demonstration will be increased through observance of the following suggestions:

1. The general principles which apply to the procedure to be demonstrated are written on the blackboard. They are then explained and discussed.

2. All articles needed for the demonstration are assembled before the class period begins and are arranged in the order in which they will be used.

3. The kind of articles that would probably be used in the home situation are used for demonstration purposes.

4. All the students are seated so that they can see every step of the procedure with ease.

5. The instructor faces the group.

6. The procedure is performed correctly. For example, when showing how to give a bed bath or bathe a baby, the instructor rolls her sleeves above the elbow as she would in a real situation. The ice cap is filled with ice, the hot-water bottle with hot water.

7. Every step of the procedure is explained, the instructor calling attention to the principles underlying the procedure, and showing each article as she talks about it.

8. The essential points are summarized after the demonstration.

9. The students are given an opportunity to participate. They are given an opportunity to ask questions and time to answer the questions the instructor asks.

10. Students are given an opportunity to practice in class and at home.

#### ADEQUATE PRACTICE PERIODS

Sometimes the instructor is uncertain how to provide for adequate practice periods for each student. The ways

listed here have been found successful:

1. The essential equipment for the procedure is set up in time for practice before the class period begins.

2. A home assignment on each procedure demonstrated is given and each student is asked to report on the following facts:

The part of the procedure which she could do with ease.

The part with which she had difficulty.

The response of the member of the family on whom the procedure was practiced.

3. Following the reports on home practice, the students may give a return demonstration of the entire procedure.

4. Provision may be made for practice of different procedures in the same class period. The class may be divided into groups. Some may practice the taking of temperature, pulse, and respiration; others may give a bed bath or practice some other assigned procedure.

Additional practice periods may have to be arranged, depending upon the needs of the individuals. The objective is ability to perform every procedure skillfully enough to assure the safety and comfort of the patient.

#### OTHER METHODS MAY BE USED

The method of informal discussion is used frequently to solve a problem about which the group has some information. The instructor may start the discussion by giving a brief statement of the problem and then a prepared question on it. The question may be written on the blackboard, and pertinent points contributed by the group may be listed under it. Or the instructor may start by asking one of the group to give a brief report on a previously assigned reading reference. Questions asked by the group and the instructor usually carry the discussion forward. Visual aids, such as charts and posters, are additional tools which will help to provoke discussion. The assignment is



another useful tool. However, certain guiding principles should be followed:

1. The assignment should be reasonable; that is, it should be neither too long nor too difficult. The instructor should consider the student's outside responsibilities.
2. It should relate to the student's own surroundings and experiences.
3. It should be interesting to the student.
4. It should be definite and clear.
5. It should have a definite purpose.

#### *Example*

The following assignment may be given to help the student in the wise selection of foods which will meet the health needs of the family: Plan menus for your own family for one week. Write a brief statement telling the number in your family, their ages, special dietary problems, if any, and the amount of money you have to spend. Bring your plan to class one week from today.

The summary when used wisely serves as another stimulus for effective learning. It should be made at the close of each major discussion to emphasize important points and to sum up the material covered. It may also be used to carry discussion forward and to stimulate thinking.

#### ESSAY AND OBJECTIVE QUESTIONS

There are two main types of questions—the essay type and the objective type. The essay type frequently begins with *why* or *how* and is effective in starting discussion, provoking thought, and testing skill, understanding, or knowledge. One of the main purposes of the objective type of question is to test knowledge of subject matter. When skillfully formulated, this type may also test understanding. The type of question used depends upon the purpose of the question and the group being tested.

The essay type of question is used to a great extent in the Home Nursing classes. It may be used in written form to test knowledge, understanding, or achievement; or in oral form to start discussion, provoke thought, set up a problem, provide repetition, or test achievement. Essay questions should

present a problem from a new angle so that the answer is not a matter of recall. They should be worded carefully so that there is no possibility of misunderstanding. Each question should have an answer made up of items, all of which combined form a complete answer to the question. Each question should present a challenge to the student and should be adjusted to his experience and ability. The question should be specific, should have only one meaning, and should center on only one idea.

#### *Examples*

State six ways in which the homemaker can stretch her food dollar.

What methods are known to cure cancer if it is diagnosed early?

The following principles should be observed in constructing all questions regardless of the type:

1. Each question should have a purpose.
2. It should be definite and have only one meaning.
3. It should present a challenge to the student.
4. It should be stated simply, clearly, and correctly.
5. Catch questions and the use of such words as "all," "always," "usually," "often," and "never" should be avoided.
6. In oral discussion, the question should be addressed to the class before the name of the student who is to answer it is given.

#### TESTING AND SCORING\*

Testing student achievement is considered one way of keeping the student informed of his progress and his needs, and is thereby a means of directing learning. Thus the achievement test is an essential part of every unit of learning. Tests may be oral, written, or performance tests, or a combination of

\* Heretofore the Red Cross has used the 75-100 grading system as a means of measuring and interpreting student achievement. A simplified system of scoring and the interpretation of the score are described in detail in the new "Instructor's Syllabus," which is available to authorized Red Cross Home Nursing instructors. (ARC 793, March 1942.) The changes are not retroactive, but will be put into effect when new classes are started.

these, and they may include essay-type questions, objective questions, performance questions, or combinations of these types. Usually at least two different types are necessary in each test. The purpose of the test determines the type of questions to be used. The instructor should write out the answers to the questions when she prepares the test.

A score is the value assigned to the answer to a given question. The instructor should assign the score value for the correct answer to each question when she prepares the test. It is recognized that items vary in importance and the value assigned to each question will depend on the instructor's estimation of the comparative importance of each question. The score assigned to an essay-type question will depend on the number and relative importance of the essential items that comprise an adequate answer. Thus if the question, "State six ways in which the homemaker can stretch her food dollar," is assigned a score of 6 when answered correctly, the student's score will depend upon the number of items included in his answer.

In scoring procedures, the score for the correct answer is determined on the basis of the essential factors without which the procedure would be ineffective. The factors usually considered are those which relate to the safety and comfort of the patient, the care of the equipment, and the use of the resources.

The total score of all questions if answered correctly and the highest possible score for each question should be explained to the students before the test is given. The highest possible score for the test will vary with each test.

After the test, the individual scores can be arranged on the blackboard in numerical order and the frequency for each score indicated opposite the score. The student can then find his own score in relation to the group. The person with the lowest score may need addi-

tional help, or the lowest score may be of no particular significance.

*Example\**

Assuming that the highest possible score in a given test is 52, the distribution score of a group of 16 might appear as follows:

Score	Frequency of Score
50-48	2
47-45	2
44-42	3
41-39	3
38-36	3
35-33	2
32-30	1

On the completion of the course, each student's scores for all tests are added and again arranged in order and frequency. This total score is reported on the final class roll report.

*Example\**

Name of student	Scores for Units				Total Score
	I	II	III	IV	
Davis, Esther	72	40	56	85	253
Jones, Mary	75	50	55	82	262
Smith, Ruth	70	50	50	80	250

When the total scores have been secured for each student, a distribution score is arranged. The following example shows two of the ways in which the scores might fall in a class of 16 students with the highest possible score 275.

*Example\**

Scores for Course	Distribution Score	
	I Possible Frequency of Scores	II Possible Frequency of Scores
265-263	1	1
262-260	0	2
259-257	2	0
256-254	1	2
253-251	2	3
250-248	0	2
247-245	2	3
244-242	3	2
241-239	2	0
238-236	0	0
235-233	2	0
232-230	1	1

The present consensus is that the achievement of groups of people generally falls into five levels. About 50 percent of the usual group are average,

\* Taken from Instructor's Syllabus, ARC 793, pages 31, 32.

about 25 percent are above average, and about 25 percent are below average. Of the 25 percent above average, about 5 percent will get higher scores than the remaining 20 percent; conversely, about 5 percent of the 25 percent below average will be somewhat lower than the remaining 20 percent. Thus the achievement of 95 percent of a group may be considered satisfactory and that of the lowest 5 percent questionable.

Each instructor will have to decide whether the student or students in each class whose scores represent the lowest 5 percent for that class have done satisfactory work and are therefore eligible for the Home Nursing certificate. If the student's work has been consistently unsatisfactory, naturally he would not receive the certificate. If a review of the work of the student shows that only certain parts of the work are weak, the instructor may arrange for additional supervised practice or other assignments followed by another oral or written test. Where the work of the student is satisfactory, even though he has the lowest

score in the class, he should be considered eligible for the certificate.

#### SUMMARY

It is generally accepted that learning does not take place until the individual changes his behavior. Mere acquisition of knowledge is not true learning. In order to provide for effective learning the instructor should:

1. Be familiar with the subject matter to be taught.
2. Know the application of the subject matter.
3. Plan the course as a series of related, coördinated units which will help the student meet specific life situations.
4. Plan each unit according to the needs and interests of the students within the scope and time limitations of the course.
5. Recognize and use teaching opportunities, selecting those methods most suitable for the purpose.
6. Evaluate and interpret the growth and achievement of the students.

#### REFERENCES

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<sup>2</sup>Jones, Arthur J., Grizzell, E. D., and Grinstead, Wren Jones. Principles of Unit Construction. McGraw-Hill Book Company, New York, 1939. \$2.

<sup>3</sup>*Ibid.*, p. 19.

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The July number will be the special Biennial Convention issue.

## Annie M. Brainard



**A**NNIE M. BRAINARD, editor from 1911 till June 1923 of *The Visiting Nurse Quarterly*, fore-runner of PUBLIC HEALTH NURSING, died at her home in Cleveland, Ohio, on April fourth.

Miss Brainard's life spanned a period of intense activity and growth in public health nursing in the United States; and her long and fruitful connection with this development of community service began with her membership on the Board of Trustees of The Cleveland Visiting Nurse Association in 1904, under the tutelage of such outstanding nurses as Isabel Hampton Robb and Matilda L. Johnson. Nine years later, in 1913, she had become the president of the Association.

In January 1909, certain members of the Board of The Visiting Nurse Association conceived the idea of bringing the associate members into a closer fellowship with the work of the nurses through the publication of "a quarterly report concerning the work done by the visiting nurses in the homes of Cleve-

land's sick poor." It was in Isabel Hampton Robb's sitting room that this idea was worked out in its practical details; and soon afterwards the first issue of *The Visiting Nurse Quarterly* of Cleveland went forth on its mission. The original Publication Committee included Mrs. John H. Lowman as editor; Miss Brainard as assistant editor; and Mrs. Hunter Robb and Matilda L. Johnson as members.

Before long this modestly conceived undertaking came to have much more than a local significance, and the magazine's subscription list soon spread over the entire country. Public health nursing was still very young and it had the energy and need for self-expression of all young things. Through the little *Quarterly*, visiting nurse associations in wide-flung areas of the country came into contact with each other, learned each other's problems, and strengthened the already growing consciousness of their national entity. It was an entirely logical development that in 1912, when the National Organization for Public Health Nursing was founded, the *Quarterly* should be presented to the new organization by the Cleveland Association and accepted as its official organ beginning in January 1913.\* However, it continued to be published in Cleveland; and in August 1918, as a direct result of wartime needs, another great change was inaugurated when the *Quarterly* was expanded into a monthly. Finally, in June 1923, the Cleveland committee turned it over to the New York office of the National Organization and to a new editor.

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\* The magazine became *The Public Health Nurse Quarterly* in January 1913. In August 1918 it became a monthly publication, *The Public Health Nurse*. Its name was changed to PUBLIC HEALTH NURSING in July 1931.

Miss Brainard was always greatly interested in the educational side of nursing, as she was in any movement that made for the better care of the sick or a finer spirit in nursing. In 1911, just a year after Teachers College of Columbia University had expanded its Home Economics course—started in 1899—and established the first Department of Nursing and Health in the country, The Cleveland Visiting Nurse Association, in connection with Western Reserve University, inaugurated "the first class on Social Training for Nurses which combined theory with practice under competent instructors and supervisors." Miss Brainard became lecturer on the administration of public health nursing at Western Reserve University in 1916, and she continued on the faculty until 1926. It was during that period, in 1919, that her first book, *Organization of Public Health Nursing*, was published; and it quickly came to be the recognized textbook on its subject. Miss Brainard was also a member of the committee on nursing education of the Flora Stone Mather College (for Women); and when the University School of Nursing was established in 1923 she became a member of the advisory committee, an office which she continued to hold until her death. Also at the time of her death she was a member of the advisory committee of the University Nursing District.

The idea of centralization had early taken a firm hold in Cleveland. The Central Committee on Public Health Nursing had been formed in 1913, as a committee of The Cleveland Visiting Nurse Association. A year later it became an independent organization, with all the public health nursing groups in the city comprising its membership. Miss Brainard became its chairman in 1922, continuing until 1935, when it became a broader Central Committee on Nursing; and she was the honorary chairman at the time of her death.

Largely because Cleveland already had experience in coöperative effort, the committee on nursing of the Council of National Defense in Washington selected that city in 1918 to make an experiment in community nursing, with the idea of bringing about the most economical use of its available nursing strength. The local committee on nursing became the medium through which this experiment was made; but while a great deal was accomplished, members of the committee realized that a full centralization of nursing effort could only be brought about by the acquisition of "a local habitation and a name." This final consummation was happily accomplished through the generosity of Mrs. Chester C. Bolton, her sister, Mrs. Dudley S. Blossom, and her two brothers, who offered the use of Perry House, the beautiful old home on Euclid Avenue, to be a Nursing Center and to house all the nursing groups of the city which were free to choose their own location. Miss Brainard was a member of the original Board of Governors of the Nursing Center and one of those most helpful in solving many of the problems which must necessarily arise in any grouping of important and sometimes diverse interests. Her keen participation in these interests never flagged, and she remained a leading member of the Board up to the end.

Miss Brainard's second book, *The Evolution of Public Health Nursing*, appeared in 1922. In it, she traced the development of organized visiting of the sick in their homes from its origin in the first century of the Christian era, down through the centuries, until it broadened out into the wide perspectives of public health nursing as we know it today. The preparation of this book entailed a tremendous amount of research, and correspondence with many people in all parts of the world. But Miss Brainard had an abundant energy; her thinking was crystal clear; and be-



cause she had travelled widely, not only in her own country but also in Europe, she had the necessary contacts to obtain first-hand assistance from those closest to the problems and developments and the historical backgrounds of which she wished to write. She knew the information she wanted and she knew where to find it; as a result, she used a minimum of time and effort of her own or of those to whom she had to turn for assistance. She spared no pains to insure the accuracy and intelligence of her presentation of her subject; and because her informants were always close to the source of the movements and accomplishments which they described, her book bears the imprint of truth and the vividness of life; while her style is always lucidly clear and sharply focussed.

Miss Brainard's contribution to the more idealistic side of nursing came largely through her long connection with the St. Barnabas Guild for Nurses, an organization which has played a quiet but none the less important part in the life and history of nursing, linking up the nursing profession with its foundations in the early Church. She believed that this early beginning was of the very essence of nursing, which should be a calling as well as a profession, since it offers a practical demonstration of Christian faith in action. St. Barnabas Guild—one of the oldest nursing organizations in the country—celebrated its Golden Jubilee in the United States in 1936, and for that occasion Miss Brainard prepared a short life of Saint Barnabas, collected from all the available sources and traditions. She spent a considerable amount of time and effort in finding a picture of the Saint, and she corresponded with and visited a number of art museums and libraries before she at last discovered one which could be used as a frontispiece to the pamphlet, which was put out in very attractive form by the Cleveland Branch of the Guild. Miss Brainard was presi-

dent of this branch a number of times and took a keen interest in its activities.

In looking back over Miss Brainard's life one immediately thinks of certain qualities which were outstanding. Her sense of justice and her honesty in facing any issue, no matter how difficult, combined with a judgment that was always clear and realistic, made her an invaluable member of any board or committee. Again and again, under varying circumstances, in many different groups and from people of quite diverse characters and often opposing points of view, the suggestion would come: "We must consult Miss Brainard!" In meetings, when difficulties or controversies arose, she was the balance of the scales. Never led astray by partisanship, she was always entirely loyal to her convictions, and when once sure that a cause or an action was just and right, her courage and effectiveness in fighting for it were invaluable. But she could never be persuaded against her judgment; her sense of rightness was unassailable. She respected all honest opinion, and she was never afraid to change her own mind if, on further consideration of the evidence, her reason told her that she had been mistaken. She expected the same honesty in others.

Another prominent characteristic was her readiness, nay her desire, to take quick and effective action once a method of procedure became clear. She believed that discussion and study must lead to concrete action; otherwise they are a mere waste of time and effort. Many a long and apparently futile argument was suddenly brought to a focus and became fruitful because of some practical suggestion or recommendation she made.

While Miss Brainard's sense of historic background and continuity were strong, her thoughts and ideas were never static. She was keenly alive to the movements and changes of the times in which she lived and never re-

*(Continued on advertising page 9)*

## The N.T.A. in Philadelphia

THE POSSIBLE effect of the war and postwar dislocation on the incidence of tuberculosis and mortality from this disease recurred throughout the papers and discussions at the annual meeting of the National Tuberculosis Association in Philadelphia, May 6-9, 1942. The challenge of the hour, as sounded by Dr. Bruce H. Douglas, president of the Association, is to "demonstrate that war need not necessarily be accompanied by a rise in the toll taken by the white plague." He outlined in broad strokes the work which must be undertaken—an extensive program of mass examinations of men entering the military service and industrial workers; provision for care; treatment in the face of limited staff; and rehabilitation which will "make use of every available worker" in "productive work suited to his physical strength."

Coupled with this determination to meet the new needs of the emergency was a plea that wartime services be planned "to gear into a stronger program when the war is over," as expressed by Dr. Ira V. Hiscock at one of the sessions of the Administrative Section.

A high light of the meeting was Dr. Esmond R. Long's paper, "Modern Trends in the Understanding and Control of Tuberculosis," in which he summarized with his usual conciseness and clarity the present-day concepts in regard to this disease, and emphases in its control from both the scientific and social aspects. Every nurse will want to read this paper when it is published.

The need for better preparation of the public health nurse for her role in tuberculosis control and the importance of using available facilities to give tuberculosis nursing experience to students in schools of nursing were emphasized in the nursing papers, which were a part of both the Medical and Administrative

Sections. These discussions were really a continuation of an unusually successful tuberculosis institute, arranged by Fannie W. Eshleman, and given at The Henry Phipps Institute preceding the meeting.

Inadequacies in the preparation of the nurse, and particularly the public health nurse, to carry out her responsibilities in tuberculosis control were frankly faced in a paper by Helen LeLacheur of Texas—read in her absence by Catherine Boughman of Philadelphia—which was part of a lively session on "The Better Use of Community Resources for the Development of a Tuberculosis Program." Miss LeLacheur discussed various tools for keeping the public health nurse informed in this field, including the use of community resources for bedside and clinical experience, staff education programs, institutes, periods of service in clinics, and integration of more tuberculosis nursing in the literature on generalized public health nursing. She believes that nurses in generalized services often are not interested in the tuberculosis service because they are not prepared to do it.

The use of the generalized agency as an adjunct to the specialized agency in the community was discussed by Ruth W. Hubbard of Philadelphia, who said that the generalized nurse should be able to apply to the field of tuberculosis her responsibility for teaching the family. Miss Hubbard described the way in which the facilities of The Henry Phipps Institute have been extended to The Visiting Nurse Society of Philadelphia to augment the education of the staff on tuberculosis, through which the general nurses hope to become "better allies of those of you who are specialists in this field." She stressed the need for periodic repetition of this "refreshing," both because of the advances in scientific knowl-

*(Continued on advertising page 10)*

# Amount of Supervision in 92 Agencies

By DOROTHY E. WIESNER

**I**N THE FILES of the National Organization for Public Health Nursing are Yearly Review schedules from many public health nursing services for a number of years.

Data concerning the growth of agencies and the increases in the number of supervisors employed are available for study from these reports. It was found that 92 agencies employing 10 or more nurses in 1939 had sent in Yearly Reviews in 1934 and also in 1939. Both the 1934 and 1939 Yearly Review schedules contained data about the number and type of nurses employed.

## *Agencies in the sample by geographical location and number of nurses employed in 1939*

The sample of agencies whose reports were available for these comparisons was composed of 64 nonofficial agencies, for the most part visiting nurse associations, and 28 official agencies, for the most part health departments. No nursing services under departments of education were included in this review. Six of the agencies were in the Pacific and Rocky Mountain states, 12 were in Southern states, 7 were in the West North Central

states, 24 were in the East North Central states, and the other 43 were in New England and the Middle Atlantic states.

Agencies employing less than 10 nurses in 1939 were not included in these comparisons because of the impracticability of employing more than one supervisor in such agencies. Of the 92 agencies included in this review, 11 employed more than 100 nurses in 1939; 6 employed from 50 to 99 nurses; 24 employed 25 to 49 nurses; and 51 employed less than 25 nurses.

## *Increases in number of nurses employed, 1934-1939*

When the number of nurses employed in 1934 was compared with the number as given in 1939 data we found that 57 agencies had increased in size; 16 had not changed; and 19 had decreased. Among the 64 nonofficial agencies, a little more than half had increased. Among 28 nonofficial agencies, more than three fourths had increased in size. Even this small sample suggests the more rapid growth of the official agencies.

There is some indication that agencies employing less than 50 nurses were more likely to increase than those employing

TABLE I  
KINDS OF WORKERS CLASSIFIED AS SUPERVISORS, BY TYPE OF AGENCY

Kinds of workers in supervisory groups	Among 92 agencies in sample		Among 28 official agencies in sample		Among 64 nonofficial agencies in sample	
	1934	1939	1934	1939	1934	1939
Total—all supervisory groups	404	480	158	216	246	264
Educational directors	15	29	1	5	14	24
General supervisors	285	342	119	148	166	194
Special supervisors <sup>1</sup>	104	109	38	63	66	46

<sup>1</sup> Non-nurse professional workers are not included. Data for the nonofficial agencies are available, and show 55 such workers in 1934 and 66 in 1939.

TABLE II  
RATIO OF STAFF NURSES TO SUPERVISORS, BY TYPE OF AGENCY

Ratio of staff nurses to supervisors	All agencies		Official agencies		Nonofficial agencies	
	1934	1939	1934	1939	1934	1939
Total	92	92	28	28	64	64
Less than 5.0	11	10	2	1	9	9
5.0-7.9	22	32	5	6	17	26
8.0-9.9	14	12	3	5	11	7
10.0 and more	21	24	9	11	12	13
No supervisors employed	24	14	9	5	15	9

50 and more, and that agencies in the Southern states increased more often than those in the Northern or Western states.

*Number of supervisors employed, 1934-1939*

Table I shows the kinds of workers that were classified in the supervisory group. Non-nurse professional workers were not included in either year. The percent of increase from 1934 to 1939 was greater among the official agencies than among the nonofficial. The number rose from 158 in the official agencies in 1934 to 216 in 1939, an increase of 36.7 percent. Among the nonofficial agencies the number in the supervisory group increased from 246 to 264, or 7.3 percent.

Obviously more supervision is available in the agencies in which the number of staff nurses per supervisor is less than ten than in those agencies in which the number of staff nurses per supervisor is ten or more. In the 1939 edition of the *Manual of Public Health Nursing* is the statement: "In order to permit constructive supervision, one supervisor

should be responsible for not more than ten nurses, including students."\*

Table II shows that in 1934 there were 24 agencies in which no supervisor was employed. In 1939 there were only 14 of these agencies in which no supervisor was employed. Nine of the 28 official agencies employed no supervisor in 1934, and nine more showed ratios of 10 or more staff nurses per supervisor. There was some improvement among the official agencies in 1939 in this respect. Among the nonofficial agencies, the number of supervisors in relation to staff nurses was higher in both years. However, in 1939, nine of the 64 nonofficial agencies employed no supervisor.

Another way to state these comparisons about the amount of supervision is to show the median for each group. Table III indicates that there were more supervisors in relation to staff nurses

(Continued on advertising page 9)

\*National Organization for Public Health Nursing. *Manual of Public Health Nursing*. The Macmillan Company, New York, third edition, 1939, p. 45.

TABLE III  
MEDIAN NUMBER OF NURSES PER SUPERVISOR

Years	Staff nurses per supervisor in 92 agencies	Staff nurses per supervisor in 28 official agencies	Staff nurses per supervisor in 64 nonofficial agencies
1934	9.9	13.3	9.2
1939	8.8	12.3	7.4

# **SCHOOLS APPROVED FOR TRAINING PHYSICAL THERAPY TECHNICIANS** **By the Council on Medical Education and Hospitals of the American Medical Association**

Name and Location of School	Entrance Requirements*	Duration		Time of Admission		Tuition**	Certificate† Diploma Degree
		Regular Course	Emergency Course	Regular Course	Emergency Course		
Children's Hospital, Los Angeles, Calif.	(a) R. N. (b) Phys. educ. major (c) 2 yrs. college	12 mos.	6 mos. 1	Feb. and Sept.	Feb. and Sept.	\$200 R \$200 E	Diploma R Certificate E
Stanford University, Stanford University, Calif.	(a) R. N. (b) Phys. educ. major (c) 3 yrs. college	12 mos. 1	7 mos. 1	Jan. and June	Jan. and June	\$420 R \$286 E	Certificate or B. A.
Walter Reed General Hospital, Washington, D. C.	Phys. educ. major	9 mos. 1	6 mos.	Oct.	Quarterly Jan. and July	None	Certificate
Northwestern University Medical School, Chicago, Ill.	(a) R. N. (b) Phys. educ. major (c) 3 yrs. college	9 mos. 1	6 mos. 1	Oct.	Jan. and July	\$200 R \$200 E	Certificate
Bouvé-Boston School of Physical Education, Boston, Mass.	High sch. grad.	3 yrs. 4 yrs. 2 9 mos.	-----	Sept.	-----	\$400 yr.	Diploma or B. S.
Harvard Medical School, Boston, Mass.	(a) R. N. (b) Phys. educ. major (c) 2 yrs. college <sup>3</sup>	9 mos.	6 mos. 1	Sept. and March	Sept. and March	\$200 R \$200 E	Certificate
Boston University, Sargent College of Physical Education, Cambridge, Mass.	2 yrs. college	2 yrs.	4	Oct.	4	\$547	Certificate and B. S.
Posse Institute, Kendal Green, Mass.	High sch. grad.	3 yrs. 1	-----	Sept.	-----	\$415 yr.	Diploma
University of Minnesota, Minneapolis, Minn.	(a) R. N. (b) Phys. educ. major (c) Medical technology grad. with B. S. degree	12 mos. 1	-----	June and Sept.	-----	Univ. fees	Certificate
Mayo Clinic, Rochester, Minn.	(a) R. N. (b) Phys. educ. major (c) 2 yrs. college	-----	6 mos. 1	-----	Jan. and July	None	Certificate
New York University, New York, N. Y.	(a) R. N. (b) Phys. educ. major (c) 2 yrs. college	9 mos.	-----	Sept.	-----	\$400	Certificate
St. Louis University School of Nursing, St. Louis, Mo.	High sch. grad.	4 yrs. 1	-----	Jan. and Sept.	-----	\$250 yr.	B. S.
University of Buffalo School of Nursing, Buffalo, N. Y.	(a) R. N. (b) Phys. educ. major (c) 2 yrs. college	12 mos. 1	6 mos. 1	Feb. and Sept.	Feb. and Sept.	\$425 R \$375 E	Certificate
Hospital for Special Surgery, New York, N. Y.	(a) R. N. (b) Phys. educ. major (c) 2 yrs. college	9 mos. 1	6 mos. 1	Sept.	Sept.	\$300 R \$200 E	Diploma
D. T. Watson School of Physiotherapy, Leedsdale, Pa.	(a) R. N. (b) Phys. educ. major (c) 2 yrs. college <sup>3</sup>	2 yrs. 1	6 mos. 1	Sept.	Jan. and July	None R \$200 E	Diploma R Certificate E
Richmond Professional Institute of the College of William and Mary, Richmond, Va.	(a) R. N. (b) Phys. educ. major (c) College grad. (d) High school grad.	9 mos. 4 yrs.	-----	Feb. and Sept.	-----	College fees	Certificate or B. S.
University of Wisconsin Medical School, Madison, Wis.	(a) R. N. (b) Phys. educ. major	12 mos. 1	6 mos. 1	Feb. and Sept.	-----	Univ. fees	Certificate

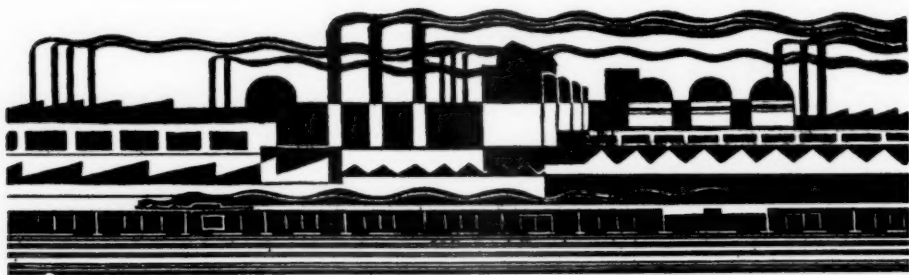
\* Courses are so arranged that any of the entrance requirements (a, b, c, or d) will qualify students for training.  
 \*\* R = Regular course; E = Emergency course.

† From Approved Schools for Physical Therapy Technicians. This group admitted to emergency course only.  
 ‡ Only those with three years of college are admitted to emergency course.

§ Emergency course offered in cooperation with Harvard Medical School.  
 ¶ The emergency course at University of Wisconsin Medical School has been added to this list.







## BLOOD TESTS FOR INDUSTRY

**I**N CONNECTICUT's larger defense industries it has become standard practice to have a blood test for syphilis made on every applicant for employment. The extent to which the Bureau of Laboratories is aiding this defense program is shown by records kept for the month of January 1942. During January, 5060 bloods identified as pre-employment specimens were received for examination. This probably is not the entire number submitted since some specimens without the necessary identification are undoubtedly being received.

Approximately two percent of these

specimens have yielded positive or doubtful laboratory tests. These figures have not yet been corrected for repeat specimens, which are taken on most of the doubtful cases, but it appears probable that the incidence of positive tests in this population group will be somewhat larger than that in the group of marriage license applicants—which shows an incidence of approximately one percent. A fair estimate cannot, however, be made until a larger sample is available.

—From *Connecticut Health Bulletin*, April 1942, page 79.

## PART-TIME NURSING IN SMALL INDUSTRIES

**T**HE following resolution in regard to part-time nursing services in small industries has been prepared by the Committee on the Development of Industrial Hygiene in Local Areas of the National Conference of Governmental Industrial Hygienists:

**WHEREAS:** It is a function of the state industrial hygiene divisions to survey industrial plants and make the appropriate recommendations, and

**WHEREAS:** The nonofficial public health associations are able and willing to extend their services so as to render

part-time nursing services to industry:

**BE IT NOW, THEREFORE, RESOLVED:** That the state and local divisions of industrial hygiene assume the leadership in developing part-time nursing services in small industries.

**BE IT FURTHER RESOLVED:** That, in developing these services, the following plan of general procedure be adopted as a guide:

1. Analyze industries by size and type of product manufactured or service rendered, and evaluate their hazards.
2. Formulate a definition of what constitutes a small-size plant.

3. Select the small industries needing part-time nursing services, and willing to consider the establishment of the services.

4. Determine the availability of nurses on staffs of public health nursing agencies, and of nurses other than those employed by the nursing agencies.

5. Plan with the public health nursing agencies in-service education programs and policies concerning type of medical service to be rendered, fees, and length of such services.

6. Secure the coöperation and guidance in the development of such services of the committee on industrial health of

the state and/or local medical society.

7. Secure wherever possible the assistance of a committee of industrial nurses organizations which may be particularly helpful in developing education programs and policies.

8. Develop nursing services in coöperation with the physician serving part-time or on call in the plant.

9. Develop a specific program for part-time nursing service in the plant according to the type of medical service and safety program in operation in the plant, the known hazards of the plant, and preparation of the nurse who will render the service.

### COURSE IS GREAT SUCCESS

A COURSE planned for nurses in industry was given this spring at Western Reserve University in Cleveland, Ohio. The 15 weeks' course was offered for credit or without credit, as the student desired, and classes were held from 7:00 to 9:00 p.m. once a week. An interesting group of 63 nurses registered for the course; most of them were active in industrial nursing, but many were from other fields of public health nursing. The content was geared to present-day needs in industry. A great deal of the

material requested by the students could not be fitted into this semester's work, but will serve as a nucleus in building a similar course next year.

One project of the class was a dramatization of a dispensary interview, demonstrating the application of principles discussed in the course, and stressing the coördination of community resources in meeting the health problems of the worker.

DOROTHY L. BERRY, R.N.  
*Cleveland, Ohio*

### NEW PAMPHLETS FOR WORKERS

TWO NEW pocket-sized, color-illustrated pamphlets for workers have been added to Workers' Health Series issued by the U. S. Public Health Service. "Trouble in the Midriff," No. 5, explains in nontechnical language the most common causes of stomach troubles, and discusses preventive measures.

"Bill Gets the Works," No. 6, presents the need for a thorough pre-employment physical examination, and describes what such an examination should consist of. Copies are 5 cents each, \$1.50 per 100, \$12.50 per 1000. Order from the Superintendent of Documents, Government Printing Office, Washington, D. C.

The Biennial Convention in Chicago, Illinois, May 17-22, was the largest ever held, with a registration of 10,766. For convention news and papers, see the July issue.



EDITED BY EVELYN C. NELSON

#### PLAIN WORDS ABOUT VENEREAL DISEASE

By Thomas Parran, M.D., and R. A. Vonderlehr, M.D. 226 pp. Reynal & Hitchcock, New York, 1941. \$2.

Because the authors believe that syphilis and gonorrhea are the chief saboteurs of the soldier and the citizen, they have taken time out of a busy program in public life to write this highly significant book. No public health nurse should be without it. It is one of the most readable contributions to public health literature in the last decade, and should have an even wider influence on public thinking than *Shadow on the Land*.

In many ways this is a most courageous book. It not only points out the extent of our progress in the control of the venereal diseases but it does not mince words about our failures. Nor does it hesitate to outline a vigorous program for overcoming them. It is a book that does not make pleasant reading.

Above all, the book puts to rest certain fallacious notions about the venereal diseases, such as the illusion that prostitution is a necessary evil which can be effectively regulated. With devastating facts and figures, the authors demonstrate the futility of a venereal disease control program which tolerates prostitution, the largest single source of such infections.

The book gives a clear explanation of

the new approach of the United States Public Health Service to the venereal disease problem. It contains an excellent appendix and a useful index.

R. MARGARET ALLEN, R.N.  
Seattle, Washington

#### NURSING: A COMMUNITY HEALTH SERVICE

By Amelia Howe Grant, R.N. 277 pp. W. B. Saunders Company, Philadelphia, 1942. \$2.50.

This is a concise and comprehensive statement of the developments and the current practice in public health nursing. It is a useful reference book "... for graduate nurses preparing for public health nursing and for students in the basic nursing education programs of study."

The book is divided into three units: Public Health Nursing in Essential Community Service, Preparation for Public Health Nursing, and Special Phases of Public Health Nursing.

In Unit I there is a brief account of public health nursing services in federal agencies and a description of the development of state and local nursing services under official and non-official auspices.

Broad principles are emphasized in the description of public health nursing services. In this connection, details of the home visits are discussed, wherein the nurse had the opportunity to observe

the relation of housing to health, of economic factors to health, of nutrition to health, and to consider such questions as: "Is there inadequate diet? If so, is it due to lack of money or lack of knowledge or to faulty eating habits?" "What kind of recreation or opportunity for social satisfaction is possible?"

The school section, in which the desirability of having as few nursing agencies as possible in the community is discussed, deserves greater elaboration. The urgent need at the present time to utilize existing nurse power effectively makes this a critical problem.

The last unit includes excellent current material on the various public health nursing services. The chapter on Maternity Nursing includes a section on

The Public Health Nurse and the Midwife. In addition to the Lobenstine Clinic school for midwives, which is mentioned, we have had for the past year the Frontier Graduate School of Midwifery and the school for nurse midwives at Tuskegee Institute. The clinic services are particularly well presented in the chapters on Tuberculosis Nursing and Social Hygiene Nursing.

Miss Grant has included a great deal of valuable information in a small volume which will assist and stimulate to further study the practicing public health nurse, the instructor, the supervisor, and the administrator in public health nursing.

NAOMI DEUTSCH, R.N.  
Washington, D.C.

#### RECENT PUBLICATIONS AND CURRENT PERIODICALS

##### SOCIAL HYGIENE

FIVE PAMPHLETS ON SYPHILIS AND GONORRHEA. Superintendent of Documents, Washington, D.C. \$1 per 100 copies.

Syphilis Its Cause—Its Spread—Its Cure!  
Syphilis and Your Town  
The Doctor Says  
Gonorrhea the Crippler!  
Are You Being Played for a Sucker?

##### DEFENSE

YOUTH AND THE FUTURE. The American Youth Commission of the American Council on Education, 744 Jackson Place, Washington, D.C. 1942. Over 300 pp. \$2.50.

Public health nurses working with children in the schools and with adolescents will find helpful information in this book, which outlines plans for a youth program to assist the young to grow into useful citizens. Emphasis is placed on health, education, social services, occupational adjustment and citizenship.

VOLUNTEERS IN NUTRITION. 8 pp., and Volunteers in Family Security, 14 pp. The Office of Civilian Defense with the Cooperation of the Office of Defense Health and Welfare Services, Washington, D.C., 1942.

Two manuals outlining opportunities, use, and training of volunteers in these health and welfare services.

TO PARENTS IN WARTIME. Children in Wartime No. 1, Bureau Publication 282. Superintendent of Documents, Washington, D.C., 1942. 5c.

This is an answer to the question of how parents should prepare for defense.

CHILD WORKERS IN WARTIME. Gertrude Folks Zimand. Publication No. 386. National Child Labor Committee, 419 Fourth Avenue, New York, N.Y., 1942. 10c.

AMERICA'S CHILDREN IN WARTIME. Reprint of three articles in January 1942 *School Life*. U. S. Office of Education, Washington, D.C.

MUMPS AS A MILITARY DISEASE AND ITS CONTROL. Conrad Wesselhoeft, M.D., and Charles F. Walcott, M.D. *War Medicine*, March 1942. The American Medical Association, Chicago. \$1.25 single copy. Bimonthly. \$5 annual subscription.

TO PARENTS IN WARTIME. Children in Wartime No. 1. Bureau Publication 282. Superintendent of Documents, Washington, D.C., 1942. 5c.

Helpful suggestions for parents in the emergency.

WAR WORK—A DAYBOOK FOR THE HOME. Department of Public Services, General Mills, Inc., Minneapolis, 1942. Single copies free. Limited quantities for classes upon request.



## NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

### FIELD SERVICE

**A**LMOST all of the staff attended the Biennial Convention of the three national nursing organizations in Chicago, beginning with the N.O.P.H.N. preconvention conferences on May 16-17. In addition to this major activity of the month, there were other field trips and speaking engagements by various members of the staff.

The general director represented the N.O.P.H.N. at two meetings, the Eighth Pan American Child Congress held in Washington from May 2-9, and the Ninth Annual Meeting of the Association of Collegiate Schools of Nursing held in Chicago on May 15-16.

Mary C. Connor also attended the meeting of the A.S.C.N., and she visited the School of Nursing Education of Seton Hall College in Newark, N.J., on April 30 and May 1 and 4.

Four talks on industrial nursing were made by D. Irene Bigler, on April 28 at Teachers College in New York, N.Y.; on May 4 at the District No. 5 meeting of the New York State Nurses Association in Endicott, N.Y.; on May 14 at The Olney Sanitarium School of Nursing in Olney, Ill.; and on May 15 at The Union Hospital School of Nursing in Terre Haute, Ind. During the Biennial Convention she participated in the meeting of the Committee to Study the Duties of Nurses in Industry of The American Public Health Association.

This year the annual meeting of the National Tuberculosis Association was held close to headquarters, in Philadelphia, and Purcelle Peck covered the sessions on May 6 and 7 for the N.O.P.H.N.

Dorothy E. Wiesner attended the meeting of the N.O.P.H.N. Subcommittee to Study Costs in Official Agencies, in Washington, D.C., on May 1. Mrs.

Josephine Prescott, director, Bureau of Public Health Nursing of the District of Columbia Health Department, is the chairman of this Subcommittee.

### HONOR ROLL

**L**ET'S celebrate the Thirtieth Birthday of the N.O.P.H.N. this June with a banner Honor Roll. To earn your Honor Roll certificate during the N.O.P.H.N.'s birthday month would be a fine way to celebrate the occasion and to show your loyalty.

All that is necessary for your association to take its place on the Roll is to see that your staff is 100 percent enrolled in the N.O.P.H.N. (One-nurse agencies too!) Then don't forget to drop us a card telling us that you are eligible. We'll see to it that your agency is on the next list published and that you receive your certificate.

A note from you this month about your eligibility for the Honor Roll will do a lot toward making our birthday month a successful one!

#### ALABAMA

\*Tallapoosa County Health Department, Dadeville

#### CALIFORNIA

\*Metropolitan Life Insurance Nursing Service, Los Angeles

\*Metropolitan Life Insurance Nursing Service, San Bernardino

#### CONNECTICUT

\*Fairfield Visiting Nurse Association, Fairfield

\*District Nurse Association of Middletown, Middletown

#### FLORIDA

\*Highlands County Health Department, Sebring

Board of County Commissioners, Indian River County, Public Health Nursing, Vero Beach

\*Agencies which have been on the Honor Roll for five years or more.

**GEORGIA**

- \*Savannah Sugar Refining Corporation, Savannah

**IDAHO**

- Division of Public Health, Idaho Department of Public Welfare, Boise

**ILLINOIS**

- \*Goodman Manufacturing Company, Chicago
- Department of Health, Evanston
- \*Evanston Infant Welfare Society, Evanston

**INDIANA**

- \*Visiting Nurse League, Fort Wayne
- \*Public Health Nursing Association of Indianapolis, Indianapolis
- District Health Department No. 3, Indiana State Board of Health, New Albany
- \*Metropolitan Life Insurance Nursing Service, New Albany

**IOWA**

- Board of Education, Dubuque

**KANSAS**

- \*Public Health Nursing Association, Topeka

**KENTUCKY**

- Clinton County Health Department, Albany
- Casey County Health Department, Liberty
- Ballard County Health Department, Wickliffe

**LOUISIANA**

- East Baton Rouge Parish Health Unit, East Baton Rouge

**MASSACHUSETTS**

- Metropolitan Life Insurance Nursing Service, Attleboro
- \*Pembroke Public Health Nursing Association, Pembroke
- \*Quincy Visiting Nurse Association, Quincy
- \*Visiting Nurse Association, Springfield

**MICHIGAN**

- Washtenaw County Health Department, Ann Arbor
- \*Public Health Nursing Service of the Civic League and City of Bay City, Bay City
- \*Visiting Nurse Association, Detroit
- \*Kent County Health Department, Grand Rapids
- \*Bureau of Public Health Nursing, Department of Health, Lansing

**MINNESOTA**

- School Nursing Service, Austin
- Community Nursing Service, Cloquet
- School Nursing Service, Cloquet
- School Nursing Service, Crookston
- School Nursing Service of the Detroit Lakes, Detroit Lakes

District Office, Minnesota Department of Health, Duluth

- School Nursing Service, Hopkins
- Hutchinson School Nursing Service, Board of Education, Hutchinson
- Koochiching County Nursing Service, International Falls
- Litchfield Public Schools Health Service, Litchfield
- School Nursing Service, Mankato
- The Dayton Company, Minneapolis
- Investors Syndicate, Minneapolis
- Minneapolis Knitting Works, Minneapolis

- Minneapolis Post Office, Minneapolis
- Pillsbury Flour Mills, Minneapolis
- Sears Roebuck Company, Minneapolis
- Division of Public Health Nursing, State Department of Health, Minneapolis
- School Nursing Service, Montevideo
- School Nursing Service, Mountain Iron
- Northfield Public Schools, Northfield
- Hubbard County Nursing Service, Park Rapids
- United States Indian Service, Ponsford
- School Nursing Service, Proctor
- School Nursing Service, Robbinsdale
- Watson County Nursing Service, St. James

- Theo. Hamm Brewing Company, St. Paul
- Ramsey County Nursing Service, St. Paul

- \*St. Paul Family Nursing Service, St. Paul

- Tri-State Telephone and Telegraph Company, St. Paul
- Oakland Park Sanatorium, Thief River Falls

- School Nursing Service, Tower
- School Nursing Service, Tracy
- Wadena County Nursing Service, Wadena
- School Nursing Service, Wayzata
- School Nursing Service, Willmar
- Kandiyohi County Nursing Service, Willmar

**MISSOURI**

- Washington County Nursing Service, Potosi

**NEBRASKA**

- Division of Child Welfare and Service for Crippled Children, Lincoln

**NEW HAMPSHIRE**

- \*Concord District Nursing Association, Concord

**NEW JERSEY**

- \*American Red Cross, Perth Amboy Chapter, Perth Amboy

**NEW YORK**

- Nassau and Suffolk Counties Committee on Mothers' Health Centers, Mineola
- \*Henry Street Visiting Nurse Service, East Harlem Center, New York
- \*Metropolitan Life Insurance Nursing Service, Oneida

\*Visiting Nurse Association of Staten Island, Staten Island

#### NORTH CAROLINA

Metropolitan Life Insurance Nursing Service, Leaksville  
City of Salisbury and Rowan City Health Department, Salisbury

#### OHIO

American Red Cross, Summit County Chapter, Akron

#### OKLAHOMA

\*Metropolitan Life Insurance Nursing Service, Oklahoma City

#### PENNSYLVANIA

\*Visiting Nurse Association of Allentown, Allentown  
West Side Visiting Nurse Association, Kingston

#### RHODE ISLAND

\*Newport Hospital School for Nurses, Newport  
\*Cranston District Nursing Association, Cranston  
\*Sayles Finishing Plants, Inc., Saylesville  
\*Warwick Health Department, Warwick

#### UTAH

\*Salt Lake Visiting Nurse Association, Salt Lake City

#### WEST VIRGINIA

Metropolitan Life Insurance Nursing Service, Huntington

#### WISCONSIN

\*Oshkosh Visiting Nurse Association, Oshkosh

#### NEW OFFICERS OF THE N.O.P.H.N.

THE OFFICERS of the Board of Directors of the National Organization for Public Health Nursing elected at the Biennial Convention in Chicago, Ill., for the biennium 1942-1944 are as follows:

President—Marion G. Howell, professor of public health nursing and dean of the School of Nursing, Western Reserve University, Cleveland, Ohio.

First Vice-President—Marion W. Sheahan, director, Division of Public Health Nursing, State Department of Health, Albany, N.Y.

Second Vice-President—Mrs. Charles S. Brown, chairman, Nursing Committee, Henry Street Visiting Nurse Service, New York, N. Y.

Treasurer—W. Lawrence McLane, associated with the Marine Midland Trust Company of New York, N.Y.

Secretary—Ruth Houlton, general director, N.O.P.H.N., New York, N.Y.

The names of directors, Nominating Committee, and officers of the sections will appear in the July issue.

### PAN AMERICAN CHILD CONGRESS

SIXTY OFFICIAL delegates from Latin American countries—most of whom traveled by airplane—and 11 official delegates from the United States attended the Eighth Pan American Child Congress in Washington, D.C., May 3-5, 1942. Many problems which our countries have in common were explored in the three sections of the Congress: Health Protection and Medical Care; Education and Recreation; and Economic and Social Services for Families and Children. Special committees also worked on specific problems: essential services for mothers and children in wartime; protection of mothers and children in danger zones; plans for children in the postwar world; and various questions regarding inter-American coöperation.

Six graduate nurses attended the convention in addition to the public health nurse consultants from the Children's Bureau: two official nurse delegates to the Congress from Colombia and Costa Rica; two individual delegates from Argentina; and two individual delegates from the United States, one from The Rockefeller Foundation and one from the National Organization for Public Health Nursing. Resolutions concerning the development of professional nursing to meet the needs of the American Republics were presented by one of the official nurse delegates to the Section on Health Protection and Medical Care and incorporated in the Final Act which was adopted by the Congress.

# NEWS

## *Highlights on Defense*



### TO USE IN RECRUITMENT

A POSTER "Become a Nurse—Your Country Needs You," in red, white, and blue colors, has been prepared by the United States Public Health Service for aid in recruitment of students for schools of nursing. The poster is 14" x 17½" in size. It has been sent to each of the 1300 accredited colleges and junior colleges in the country and a supply for distribution among high schools and other interested groups has been furnished to state nursing councils on defense. Requests for copies of the poster should be sent to your state nursing council.

"TO THE SHORES of Tripoli," a new motion picture in Technicolor released in March by Twentieth Century-Fox, can also be used to interest young women in nursing. The heroine of the picture is a Navy nurse. The Committee on the Recruitment of Student Nurses

of the National Nursing Council for War Service emphasizes that if the picture is to be effective in recruiting well qualified student nurses, it should be accompanied by definite plans for emphasizing the importance of adequate preparation in a good school and the urgent need for nurses to serve their country not only in the Army and Navy, but in civilian hospitals and many other posts of duty.

### LOAN OF MISS HAUPT EXTENDED

THE Metropolitan Life Insurance Company has extended the period of its loan of Alma C. Haupt to the Health and Medical Committee of the Office of Defense Health and Welfare Services, to serve as executive secretary of the Subcommittee on Nursing. Marie L. Johnson, assistant director, M.L.I. Nursing Bureau, Welfare Division, has been appointed acting director of the Bureau during Miss Haupt's absence.

### NEWS FROM NURSING COUNCIL

THE SUPPLY and Distribution Committee of the National Nursing Council for War Service held its first meeting in Philadelphia on April 16, 1942. This Committee consists of Katharine Tucker, chairman, Louise L. Baker, Gertrude S. Banfield, Helen Bean, Katharine J. Densford, Laura Grant, Ruth G. Hall, Alma C. Haupt, Pearl McIver, Marian G. Randall, Emilie G. Sargent, and Anna L. Tittman. Mrs. Dorothy W. Conrad has been lent for four to six months by the City and County of Denver, Colorado, to serve as secretary.

Meeting the need for nursing service to the armed forces will take precedence over civilian needs in the Committee's program. The program to be initiated

by the Committee immediately will include:

1. Plans for distribution of the guide, Distribution of Nursing Service During War.
2. Consideration of priorities in nurse distribution.
3. Assistance in modifications of local program when need is indicated.
4. Promotion through state nursing councils of rapid organization of local nursing councils.
5. Promotion of local committees for guidance and consultation for the individual nurse and for nursing organization.

#### STUDENT RESERVE FORMED

THE Red Cross Nursing Service is organizing a Student Reserve in order that student nurses may become more closely associated with war nursing, and to expedite their enrollment in the Red Cross Nursing Service and thereby make them more readily available for service with the armed forces. All student nurses in the last half of their senior year in schools of nursing which meet Red Cross requirements are eligible for membership in this reserve.

Already these students are joining the Student Reserve with enthusiasm. They are not only enrolling but are doing so with the idea of serving. As soon as a Student Reserve nurse completes her course of study and passes her state board examinations, she becomes a full-fledged Red Cross nurse. When the senior student enrolls in the reserve she will be given a student reserve badge, which will be exchanged for the Red Cross Nurse's badge as soon as she is eligible for full membership.

It is anticipated that there will be a senior representative from each school developing a reserve, who will serve with the Local Committee on Red Cross Nursing Service. This representative will help develop Red Cross nursing activities among her classmates. Schools of nursing which are interested in developing a Student Reserve are asked to consult the secretary of the local committee on Red Cross Nursing Service.

#### FIRST AID CLASSES FOR NURSES

CLASSES of instructor candidates, comprised entirely of graduate nurses, may now be given a complete training course in first aid by the American Red Cross in 30 hours. This course, to be conducted by representatives of the American National Red Cross, can be taken by nurses who plan to teach first aid, instead of the usual 45 hours, divided into 30 hours of preliminary training and 15 hours of advanced training for teaching. The course can be arranged with the local Red Cross chapter, which will in turn receive help from the Area office. Details in regard to plans for this course for nurses are given in the article, "First Aid Instructor Courses for Nurses," by Harold F. Enlows, appearing in *The American Journal of Nursing*, June 1942, page 626.

#### "EDUCATION FOR VICTORY"

A NEW official magazine of the U. S. Office of Education has replaced *School Life* for the duration of the war. The publication will be bi-weekly in order to bring to its readers "important official announcements; timely, current reports on emergency programs; statements and plans of various Federal Government agencies vital to education; information and reports on war and defense efforts affecting education." The yearly subscription rate is \$1 payable in advance. Order from the Superintendent of Documents, Government Printing Office, Washington, D.C.

#### MAIL TO PRISONERS IN FAR EAST

MAIL ADDRESSED to American prisoners of war and interned civilians held by Japan in the Far East may now be sent by friends and families in this country through the International Red Cross Committee in Geneva. Friends and families of men of the armed forces are, however, advised not to send mail

(Continued on advertising page 8)



## *From Far and Near*

• Mrs. Homer Gage, president of Worcester Society for District Nursing, Inc. (Massachusetts), and Rosebelle Jacobus, executive director of the Society, received honorary degrees for civic service from Clark University in Worcester at commencement exercises on Sunday, May 24.

Mrs. Gage was awarded the degree of Doctor in Civic Leadership and Miss Jacobus, the Master in Civic Service degree. Clark University is opening its doors to college women for the first time this fall.

• Dr. Claude C. Pierce has been appointed medical director of the Planned Parenthood Federation of America, Inc., 501 Madison Avenue, New York, N.Y. Dr. Pierce was formerly medical director in charge of Public Health Service, District No. 1, of the United States Public Health Service.

• The Montana State Nurses Convention will be held at Missoula, June 2-4.

• The following are the newly elected officers of the Texas State Organization for Public Health Nursing:

President—Grace Buzzell, Austin

First Vice-President—Irma Dixon, Beaumont

Second Vice-President—Imogene Smith, Austin

Secretary-Treasurer—Doris Robertson, Austin

Nurse Board Members—Ella Patton, San Antonio; Ruth Jane Moore, Bryan

Lay Board Member—Elizabeth McGuire, Austin

• Twenty-eight awards have been made to winning cities and counties in 17 states in the National Health Conservation Contest, conducted jointly by the Chamber of Commerce of the United States and the American Public Health Association. This 1941 contest—which was the thirteenth year of the city con-

test and the eighth year of the rural contest—has been found to be an effective means of focusing public attention upon the strengths and weaknesses of local health services and upon the need for maintaining effective health protection at all times.

The winning cities are:

Detroit, Mich.  
Evanston, Ill.  
Greenwich, Conn.  
Hackensack, N.J.  
Hartford, Conn.  
LaSalle, Ill.  
Louisville, Ky.  
Madison, Wis.  
Memphis, Tenn.  
Milwaukee, Wis.  
Newton, Mass.  
Racine, Wis.  
Reading, Pa.  
Schenectady, N.Y.

The winning counties are:

Alger-Schoolcraft Counties, Mich.  
Arlington County, Va.  
Davidson County, Tenn.  
Fayette County, Ky.  
Forsyth County, N.C.  
Gallatin County, Mont.  
Gibson County, Tenn.  
Glynn County, Ga.  
Lauderdale County, Miss.  
Madison County, Ky.  
Saginaw County, Mich.  
Santa Barbara County, Calif.  
Thurston County, Wash.  
Whitman County, Wash.

### NEW APPOINTMENTS

Miriam Christoph, industrial hygiene consulting nurse, Bureau of Industrial Hygiene, U. S. Public Health Service.

The Metropolitan Life Insurance Company announces the following transfers of territorial supervisors:

Marjorie Adams, Southern Territory  
Henrietta Bonheyo, New England Territory  
Margaret Leddy, Great Eastern Territory  
Mrs. Lenna Longdon, Central Territory

# Personality Plus FOR THE VISITING NURSE

in these popular

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FOR 1942



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Nurses prefer Rosalia Uniforms because of their professional simplicity, smartness, lasting utility and sound value. They are skillfully tailored from a wide range of fine Sanforized shrunk materials, in accepted guaranteed colors.



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Pictured are two popular shirtwaist models. See other distinctive styles, and swatches of guaranteed materials, without cost or obligation.

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Dept. 3-G

Please send without obligation your Public Health Nurse Uniforms Folder.

Name

Address

City  State

## Defense News

(Continued from page 838)

on the mere assumption that persons have been taken as prisoners. Until the names of individuals appear on the official lists released by the Provost Marshal General, arrangements cannot be made to forward mail to them.

Letters sent to prisoners of war require no postage. Free postage for prisoners' mail is provided for under the terms of the Red Cross-sponsored Geneva Convention of 1929 and the Cairo Postal Convention of 1934. The Japanese government has agreed to abide by the stipulations of the Geneva Convention which established rules for the treatment of prisoners of war.

Mail to prisoners of war should not be addressed to the American Red Cross. Until more complete information is received giving the prisoners' identifying numbers and complete prison address, the Red Cross office suggests that mail be addressed as follows: John Doe, military title and branch of service, formerly of (Wake, Shanghai, et cetera), American Prisoner in Japan, c/o International Red Cross Committee, Geneva, Switzerland. In the space usually reserved for postage stamps should be written, "Prisoner of War Mail, Postage Free."

## BULLETIN ON EDUCATION

A BULLETIN has been published by the American Council on Education entitled "The Education of Nurses for National Service—How Colleges and Universities Can Help." Included in this bulletin is much of the material presented at the January conference held under the auspices of the American Council on Education. This publication may be secured from the American Council on Education, 744 Jackson Place, Washington, D.C. (Price 40 cents.) The Council has printed in addition a list of colleges and universities that replied to a questionnaire sent out by the Association for Collegiate Schools of Nursing stating what courses and programs in nursing they plan to offer during the summer.

# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## Nurses and the War

**W**HAT ARE our responsibilities as nurses, as public health workers, as citizens, in this war? How will it affect our personal lives, our work lives? What adjustments can be made to meet today's emergency? Ten thousand nurses came to the 1942 Biennial Convention in Chicago—the largest in history—seeking answers to these questions. The convention program, much of it revamped after our entry into the war in December, was geared to the needs of the hour.

War and what it can mean to civilians was grimly brought home to us in the first general session when Dr. Philip D. Wilson, just returned from England, described what happens when a bomb falls and how the injured are cared for. Colored moving pictures of the work of the American hospital unit in England showed the newer treatment of war injuries. We viewed this demonstration of modern medical science with mingled feelings—reassurance at the skill which can salvage and rehabilitate patients whose injuries would in other wars have meant death and life-long crippling, and horror at the destructive ends to which scientific knowledge can also be used. (See page 366.)

Economic and social changes which touch closely the lives of us all were discussed by Maynard C. Krueger of the University of Chicago in an address which gave a broad social setting for the professional meetings. His warning of the dangers to be avoided in the transition from peace to war and his challenges to work toward a better social order were referred to often in subsequent meetings.

"We need bold strokes," said Mr. Krueger, "in the field of equality of opportunity, in the field of racial equality, in the field of providing equal access to all the basic facilities of life in the midst of peace or in the midst of war." (Page 353.)

The theme of responding and adjusting to changes brought about by the war ran through practically every meeting of the convention, from the great joint sessions in the Chicago Coliseum to the smallest round tables for discussion of specific problems. Rationing and priorities were the words of the hour.

### RATIONING OF TECHNICAL SKILLS

Rationing of "essential foods and commodities" is necessary in order "to provide an equitable distribution of the things we have, on the basis of actual need rather than purchasing power," said Dr. Thomas Parran in his address on "The Health Needs of the Nation" at the opening joint session. "Similarly, we shall need to ration the technical skills of the nation." If as Dr. Parran believes, "... to the life-saving forces of our professions belongs the leadership of constructive effort both now and after the war," then "... we must show ourselves responsible enough to merit that leadership by directing our whole capacities to the war needs, by diluting our professional skills with amateur assistance, by changing peacetime standards to meet the impact of total war." He called for planning of personnel which would meet the increasing demands of the military services, "make the wisest possible use of our remaining

professional force . . . and in the meantime . . . do everything possible to increase the number available."

Dr. Parran listed health needs which must be met—provision of community sanitation and medical facilities in boom areas; prevention of epidemics; control of tuberculosis and venereal disease, which always increase in wartime; and protection of health of workers in defense plants, where "pressure for speed and continuous production tends to relax vigilance and to delay proper servicing and repair of machines"—a frequent cause of accidents.

Priorities and rationing of medical personnel as the only methods of safeguarding civilian health while meeting military needs were also stressed by George St. John Perrott in the N.O.P.H.N. program on public medical care. Pointing out that our health services were inadequate in many areas even before the war, he described federal programs developed to date for spreading health personnel and facilities as effectively as possible. (See page 392.) Various plans under governmental and private sponsorship for extending medical care to all the population on the basis of need were discussed by Michael M. Davis at the same meeting.

Our progress so far in meeting our three great needs for nursing—service for the armed forces, service to civilians, and preparation of future nurses—was described by Marion G. Howell, new N.O.P.H.N. president, at a joint session. (Page 346.)

Specific ways of maintaining standards of professional education so as to assure "the quality of students and of the product of our nursing schools" were outlined by George F. Zook, president of the American Council on Education, at the joint session on education. Stressing the responsibility of the profession for maintaining its educational standards, he said the time has come to move from quantitative to qualitative

standards in accreditation of institutions for nursing education and to use new methods for measuring the quality of the product of nursing schools. He emphasized that we must now keep in the schools an adequate number of qualified teachers, so that we will not "use up our seedcorn." Finally, we must secure the interest of colleges and universities in nursing education and adequate financial support for it.

#### ADJUSTMENTS IN OUR FIELD

Against the general background of the social picture today and the broad health and nursing needs of the nation, adjustments of public health nursing to war conditions were discussed in practical and concrete ways from many angles. The public health nurse's job in the emergency was outlined by Marion W. Sheahan, with suggestions for methods by which a community and its individual agencies can analyze their program in relation to total community needs and make a beginning toward joint planning to meet these needs more efficiently and economically. (Page 371.)

Round-table discussions showed that all phases of public health nursing—in official and nonofficial agencies, industrial and school health programs, college health services, even summer camps—are already affected by the war. Personnel curtailments together with expanded programs in many areas and agencies are creating acute problems.

Especially important were three round-table discussions on adjustments in the emergency—in education of public health nurses, supply and distribution of personnel, and administrative plans.

New adaptations of former educational concepts and plans were discussed from the viewpoint of various agencies—federal, state, and local—and in relation to a joint plan between a university and a nonofficial agency. How can nurses be prepared for public health nursing with the greatest possible

economy to all concerned, without sacrifice of high standards? Ways in which six agencies have approached this problem were discussed, including better methods of selection of staff, careful analysis of all jobs in the agency, sharing of special consultants between agencies, and inter-agency planning both on state and local levels.

The supplying and distributing of nursing personnel were also discussed by representatives from federal, national, state, and local agencies. Public health nurses have certain definite responsibilities for the organization of nursing for the emergency in their communities, according to Mrs. Elmira Wickenden, of the National Nursing Council for War Service. They should (1) assume leadership in organizing local nursing councils (2) help the council to use volunteers effectively (3) promote the development of well equipped local nursing units under the Office of Civilian Defense (4) promote the use of older nurses on the home front (5) urge and assist with a "ruthless" survey of their own agency programs to see whether they are prepared to meet the total community needs.

Administrative adjustments on a state and local level as described in the round table on that subject encompassed a wide range of plans and program changes. Group instruction received special emphasis—here and throughout the meetings—as an effective method of spreading nursing service and developing a nucleus of informed citizenry. More efficient planning of visits made by state consultants to local nurses, more careful planning of home visits, increased use of volunteers and intensified lay participation in the service, modifications of postgraduate and in-service educational programs, postponement of certain peacetime projects—these were some of the points discussed.

Board members discussed with nurs-

ing administrators various changes which their agencies are facing, in four lively round tables covering many questions of agency policy and program. The layman's responsibility for assuring an adequate number of qualified nurses to meet the country's future needs was considered in two important sessions, one a joint meeting of the National League of Nursing Education and the N.O.P.H.N. The public health nursing agency's contribution to the student's education was the subject of another round table.

Old problems still with us were discussed—both in round tables and at the N.O.P.H.N.'s popular pre-convention group conferences—but with new focus to meet changing conditions: tuberculosis, especially in the industrial worker; venereal diseases in military and industrial defense areas; poliomyelitis and other crippling conditions; maternal care; the health of the school child; nutrition, to which an entire general session was devoted.

Can America produce enough food during wartime—to meet our needs and those of our allies? This question was answered by Oris V. Wells of the U. S. Department of Agriculture with a blueprint of the government's agricultural program to assure adequate production. (Page 361.) A sane, unexaggerated picture of our nutritional status and needs on a national scale was given by Marjorie M. Heseltine, consultant in nutrition of the U. S. Children's Bureau. The Farm Security Administration program for the most underprivileged group of our rural people to make them self-supporting, healthy, and adequately nourished, was described by Erna E. Proctor, regional home economist of the FSA. (See June issue, page 296.)

The necessity for facing the reality of a completely changed world and for looking forward rather than back—in the fateful manner of Lot's wife who became a pillar of salt—was



emphasized by Walter Lippmann in his address, "The American Cause," at the joint Red Cross Session. (See *American Journal of Nursing*, July issue.) Mr. Lippmann outlined "the reasons why we can never go back to things as they were between the two world wars," and the future that faces America if we do not win the war. He said that "though each one of us is a little creature in the midst of great events, we must see all things greatly or we do not see them at all . . . all the things that touch us directly—first and above all, of course [those] who have gone away from home to camps and across the seas . . . all the things which we must give up, all the things we are called upon to do; the taxes, the rationing, the strain upon our habits of life, the uncertainties of our personal future, the inroads upon our professional privileges and rights and ordinary routines." But—"In our keep-

ing there lies the future of mankind upon this earth."

Winning the war is, however, not enough. There is much more to be done, both now and after the war. In Mr. Krueger's words, "The slogans which used to ring the bells in men's hearts will no longer ring the bells unless some real content be put into them. . . . The things we say we do . . . are better than the things you can hear said in any other country in the world." But "now is the time to close the gap between the things we *do* and the things we *say* we do." This appeal, which resounded again and again throughout the convention, might well be taken as the goal for our professional life as well as for the building of "the social order of the future under which we are going to live,"—when as Dr. Parran said, "A new life must be built upon the scorched earth."

P.P.

## N.O.P.H.N. BOARD OF DIRECTORS

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*Term expires 1944*

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MARION G. HOWELL



MARION W. SHEAHAN



MRS. CHARLES S. BROWN



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# Nursing Needs of the Nation

By MARION G. HOWELL, R.N.

**A thoughtful analysis of our nursing needs today, presented at the joint opening session of the Biennial Convention in Chicago by the new president of the N.O.P.H.N.**

**A**S WE American nurses are here assembled in national convention, we know that we are at war; that death and destruction are about us; that world conditions are changing from hour to hour. We are mindful of our sister nurses in other countries at war, of our good friends in England, in Finland, in Belgium, in China, in Norway, in Canada, and in Australia. Many of them have been our cordial and delightful hostesses for international meetings and our inspiring guests in this country. We are mindful of our own sister American nurses now with the armed forces in foreign countries, and especially of those who have served so bravely and so brilliantly at Bataan.

All of us, in whatever land, have been struggling in the dark, hoping to see a light to guide us so that we may best serve humanity. Each day we realize more sharply that this is total war; that it demands our total effort, calls for our total resources; and that victory can come only to a people geared together in thought, organization, and action.

Some two years ago, leaders of our nursing groups, realizing that our problems needed to be approached imaginatively rather than conventionally, proposed plans. Committees were formed. We now have the machinery set up on a national basis which provides for the pooling of all the resources of our profession, not only through our own professional organizations, but also in direct connection with our Federal Government. Representatives of state organ-

izations have met with national leaders to determine methods for developing similar machinery within states and local areas. At other sessions of this convention, the organization programs of local, state, and national nursing groups for war service will be discussed.

Surely progress has been made in our national nursing organization for war service. However, if we are to meet the nursing needs of the military and civilian population, we must realize that this crisis is greater than any individual, and that all nurses, entirely forgetful of self, must give their all and serve their country as professionally trained women. This will require unusual leadership in local, state, and national groups. Leadership depends upon courage, wisdom, and complete forgetfulness of self. If we have these qualities, and rigid self-discipline, we can cheerfully do all the things which are asked of us, conserve materials which are important for victory, stay at home and like it.

In our plan for national organization we have been fortunate in the national leaders appointed to the councils and committees, and particularly in the full-time personnel of the National Nursing Council for War Service, the American Red Cross Nursing Service, the Subcommittee on Nursing of the Health and Medical Committee, and the other federal agencies. We have also been fortunate in having funds provided for the work of these national groups, and for a national survey of registered nurses of the country. Through this survey we

know that there are 300,000 registered nurses in the United States and that two thirds of these nurses are now employed.

#### NURSING FOR THE ARMED FORCES

America's fighting forces need nurses in the ratio of six nurses to every 1000 men in the Army and three nurses to every 1000 men in the Navy. The number of nurses must be increased in proportion to the growth of the armed forces. The projected army of seven million men will require 42,000 nurses, more than four times the number in service at the beginning of 1942. Hospitals within this country need more than 17,000 additional nurses, and public health agencies report the need for 3000 public health nurses. We must also expect new demands in the future growing out of the annual increase in hospital beds and expanding public health nursing services.

We know that the Nursing Service of the American Red Cross is charged by Act of Congress with the responsibility for maintaining the First Reserve of nurses to care for the armed forces of the government. About 11,000 nurses have been supplied to the Army and Navy through the Red Cross. This leaves about 20,000 in the First Reserve, from which about one in five may qualify for military service. When the national nursing survey was made, about 100,000 nurses were eligible for military service, at least on the two requirements of age and marital status. It is believed that the number of those who have become ineligible because of overage or marriage in the last two years will be replaced by the number of new graduates coming in. It is estimated that every second nurse of those in the eligible 100,000 will be needed for military service. This change is made because we know *all* the 100,000 will not be eligible because of physical defects, or educational qualifications.

Those of us who are closely connected with schools of nursing realize that there

is greater interest in military service than there was a year ago. This is most encouraging, and with the close coöperation of the enrollment service of the American Red Cross and the nursing services of the Army and Navy, an accelerated program in recruitment and assignment is under way. Surely no young nurse could listen to the broadcasts of our nurses in Australia and not feel a strong urge to become a part of the military service immediately.

#### CIVILIANS NEED NURSING CARE

This brings us to our second big need, namely, that of service to civilians. As stated above, civilian hospitals now have vacancies for over 17,000 nurses, and public health agencies have reported a need for 3000 more. While these services may not have the glamour and allure of those in the Army and Navy, they are nevertheless equally important. In industry an extra day of illness means an extra day off the production line. With physicians and dentists being called to military service, it is more important than ever that well people be kept well; that expectant mothers have adequate care; that children be well born and well nourished; that communicable diseases be controlled; that the worker have the best of health; and that all of us look to our daily routines to ensure a balance of work and play, food and fun, so that our own production may be maximum.

Our local agencies have been perplexed to know how to meet civilian nursing needs. A comprehensive plan is needed to devise adequate service for all civilians, as well as for all military groups. There are encouraging reports from several states where nurses engaged in private duty nursing are joining forces with those employed in hospitals to work out plans for a more even distribution of nursing service. There is now a national committee dealing with the problems of supply and distribution of nurses. With the rapid development of hospitals and

the greater utilization of hospital service, a sufficient number of qualified nurses and nursing auxiliaries must be prepared to give nursing care to the general public. Perhaps one of the greatest needs is for a review of nursing programs to be certain that nurses are utilized only for work which requires nursing skill. Can we recommend that nurses be employed for nonprofessional service in industry when their knowledge and skill as *nurses* is so vital to the health of our citizens?

We have long recognized the need for a community plan providing for the care of the sick in the home on a part-time basis as part of a coordinated public health nursing program. We should also have a community-wide plan to utilize available nurses and auxiliary service economically, efficiently, and wisely, to meet the greatest needs. This is more difficult because it cuts across agency traditions and personnel prerogatives. Even so, community planning, followed by effective action, seems to be of paramount importance.

Many of us have for years hoped to develop a plan for an interchange on the job of private duty nurses, public health nurses, and general hospital staff nurses. If the working conditions of these groups could be more nearly uniform, the workers, as well as the general public, would gain much from such an interchange. One nurse might then care for the same individuals whether at home or in the hospital. Surely our profession can bring about a happy solution to this problem. The position of the hospital staff nurse is growing increasingly important, and in this world crisis, constructive developments will need to take place.

#### PREPARING OUR FUTURE NURSES

A third great nursing need in this country concerns nursing education. We have been told by Surgeon General Thomas Parran that when the war is over, "we shall need nurses and doctors in

untold numbers to prevent complete collapse."

Important studies of present nursing educational plans have been made. Experts in education have been consulted. There have been conferences with representatives of the American Council on Education. College presidents and faculties are more than interested in guiding their capable young women graduates into schools of nursing. An excellent committee on recruiting is hard at work, bringing to the general public a realization of its responsibility not only for the education of the nurse but for recruitment of the type of young women who should enter this field. Pending national legislation may provide as much as four million dollars to assist nursing education this next fiscal year.

#### SOUND PLANNING IS ESSENTIAL

There is an increased interest in centralization of nursing education, and there is great need to study and to plan for more sound and constructive education for nursing. In some parts of the country it is reported that only those schools which have no connection with universities are having any difficulty in obtaining students. However, each school, each locality, each state, and each responsible national group must be very active and work continuously in this matter of guiding the more mature, the more intelligent, the more responsible young women into this exacting profession. Many nurses are of the opinion that recruitment should be directed to women who have had at least two years of college, and as far as possible, to the college graduate.

Many college faculties are now realizing that nursing is an important field of service for the college woman. In this world crisis, when we see the valuable service which nursing contributes to the health and happiness of mankind, is it too much to expect that nurses and the general public will together bring



into being a plan of nursing education which is truly education? If we, as nurses, will give this united support, it will be done! No other profession has so long neglected its opportunities for affiliation with institutions of learning, where the educational program is safeguarded. Each of us here knows that many of the finest young women of the country would like to enter the profession, but we have not as yet offered in every state a program for nursing education which is sound, effective, and inspirational.

As we begin this Biennial Convention, we hope that each one of us may feel the responsibility of thinking, planning, and acting together; that we do not come to this conference to get, but to give; that we try to see nursing as a whole and feel our responsibility, not only for ourselves, but for our fellow nurses; that we not wait to be told what to do and how to do it, but that each of us offer herself and her resources to the service of humanity, forgetful of self, courageous, with a will to do and a singleness of purpose which will persist until our aims are accomplished. We know that one of the great dangers of the present crisis is that we will do too little, or that we will serve too late.

#### WINNING THE PEACE

Someone has suggested that after the armistice is signed the soldiers of all countries be kept in service for a time to work together toward rebuilding the world. Similarly, in all probability the nurses of many countries will be brought together in the reconstruction of a new social era. We shall be called upon to serve not only as nurses, but as citizens. If we are to measure up to our opportunities, we must take a much more active part in shaping the political, economic, and social pattern of our communities.

Our older sisters fought diligently to give us the vote. We are in a strategic position to influence the thought and actions of others, to help them understand the values as well as the needs of those who are less fortunate.

We as nurses will need to be better informed on politics, economics, and social problems than ever before. We must be ready to share, and to help others see why *all* must share if we are to have world peace. We need to look ahead to what new problems victory may bring us. What plans have we for reconstruction in our own field of health and nursing? How much of this will depend on each individual nurse! Annie Goodrich has very aptly said, "Our profession can only go as far as the majority of the profession go."

May we say then that the great nursing need of the Nation is that each nurse look to herself; that she measure up to the code and creed of her profession, realizing that nursing exists only for the care of others. In measuring up to the standards of her calling she will volunteer for service to her country, for military needs, for teaching, or for the less exciting work of caring for the humblest citizen at home. She will zealously safeguard the standards of nursing education and nursing service, and give thoughtful and enthusiastic support to schools of nursing affiliated with universities.

As we go into this important week of conferences may we be granted vision, wisdom, strength, and courage to meet the nursing needs of the Nation more effectively and quickly. Let us say with Prime Minister Churchill, "We shall drive on to the end and do our duty, win or die. God helping us, we can do no other."

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Presented before the Joint Opening Session, Biennial Convention, Chicago, Illinois, May 18, 1942.

# The Biennial Was Thought-Provoking

By DAPHNE F. OVERBECK

A board member from New England gives her impressions of the 1942 Biennial Convention in Chicago

OUR WEEK at the Biennial Convention in Chicago was delightful, memorable — and yet thoughtful, almost somber. It wasn't a hilarious week. None of us was as care-free as we were two years ago in Philadelphia, although even then the horizon was black with the approaching storm. Now, though we feel its physical impact only indirectly, the war is always present in our minds, pushing aside our lighter preoccupations.

At the Biennial we got help from one another and from the many excellent speakers, regarding our specific problems: how to analyze our service in terms of community needs; how to cut down service; how to expand it; how to make use of volunteer assistance; how to assure continued financial support. The one big problem is, as we—lay people and nurses alike—all know: Where is the public health nurse's skill most needed for the winning of the war?

In all our discussions and in many of the talks heard at the meetings this problem was implicit. Although we came away with no hard-and-fast solution, I think we are far better equipped now to give clear and honest thought to the question: Shall the public health nurse go or stay?

Some of us concluded in our midnight discussions that if civilian health is as important in total war as we believe it is, and if the nurses we employ are important tools in conserving it, we need to go further than analysis and adjustment of our programs. The burden that is

placed on the individual nurse's conscience is one each individual lay member must share. We need to ask ourselves searching questions about the public health nurse in our own agency, even if the true answers make us wince.

Is the nurse on our staff really engaged full time in public health nursing, or part time in clerical work that you or I could do? Is she spending more time walking her automobile-sized district, or driving—and waiting for—a fellow-nurse, than on her work itself? Is she frustrated in her attempts at referral of patients because agency boards can't get together? How much does her effort duplicate that of other community workers, due to our own lack of enterprise in pushing co-ordination?

We feel her work with the families of our town is valuable. Do we ever bother to tell her so? Do we constantly work for the popular acceptance of public health nursing as an essential wartime activity? Do we encourage or discourage the nurse's participation in the kind of civilian defense work she can do best? Do we shield her from pressure to take on routine civilian defense tasks that you or I could do as well? Are we in an obvious state of disturbance about the financial future of our agency, so that she has a feeling her job may crumble at any minute?

Are we so aggressive about wanting her to stay with us that she feels we are putting ourselves in open competition with the government? Or are we expressing so feebly our convictions about the importance of civilian health that she enlists against her best judgment? And, hardest of all, are we prepared to

*(Continued on advertising page 8)*

# "Nursing at the Nation's Service"

By HENRIETTA LANDAU, R.N.

A public health nurse from the Convention city gives her impression of this year's Biennial

WE WONDERED, and like many others, had misgivings. With the world at war, with time so short and needs so great, could nurses be spared for one week away from their own communities? Would they attend the Biennial Convention? Attendance figures proved they both could and did. The Philadelphia 1940 Biennial drew 7500 members; Chicago, in 1942, was host to 10,766 nurses. Every state in the Union was represented. Canada, too, came to share her thinking with us.

"Nursing at the Nation's Service." There was a familiar ring to this theme. "Our real problem," said Adelaide Nutting in 1918, "is not only how to mobilize enough nurses for our Army, but how to mobilize our whole body of nurses for all the people."\* Today, as in 1918, when catastrophe strikes the entire world we as a body gathered to deliberate how nursing can best meet the present needs of the entire nation and prepare for future needs. We had grown in numbers since 1918. Yes—but how equitably, how soundly had our nursing service been distributed? And had the quality of our service kept pace with our growing numbers?

The nation's nursing needs must be met. The general feeling throughout the Convention was that the responsibility for leadership necessary to plan, organize, and guide the nation's nurse power to meet these needs rests squarely upon

the shoulders of the profession itself. Analysis of the most urgent needs seemed pertinent.

Where are we needed most? In the armed services? In the hospital? In the communities outside the hospital? Are public health nurses offering truly essential services? Are all nurses carrying on some activities that might well be taken over by less trained personnel? Is there still much duplication and wasted effort because we have failed to act in terms of community service, in spite of giving years of lip service to these words?

In her 1940 N.O.P.H.N. presidential address, Grace Ross stated, "There has been little obligation toward an over-all plan of combined usefulness and purpose in community life, and we are aware of the stresses which now confront us as a changing world proves our preparation to be inadequate." Have we made any progress in these two years?

Maynard Krueger in his discussion of wartime adjustments made a strong plea that we try to close the gap between the things we *do* and the things we *say* we do. He warned us also never to lose sight of the long run, even though in an emergency we may be forced to take the short run. He believed that, as a democracy, we are going in the right direction *too slowly*. How applicable to our own professional activities!

Marion Sheahan followed with some concrete suggestions for public health nursing under war conditions. Nursing organizations are apparently united at the national end, but how united are we at the local end? The guide on "Distribution of Nursing Service During War," prepared by the National Nursing Council for War Service, was widely

\* "Nursing—for All the People," *The American Journal of Nursing*, March 1942, page 294.

quoted. In fact, many of the round-table discussions evolved about the questions which were suggested in the guide as "Principles That Apply to All Types of Nursing Service."

There was growing evidence that we *are* closing the gap between accepted principle and actual practice. Contributions made by speakers from all parts of the country indicated that community needs are being studied, nursing resources are being pooled, and nurse power is being intelligently rationed and diluted. Even in a city as large and complex as New York, the busy administrators of the three largest agencies offering public health nursing services meet weekly to discuss their mutual plans. Could this not be tried in smaller communities?

A glance at the program of the N.O.P.H.N. meetings reveals some interesting trends. A nursing group asked for a discussion of "Needs for Public Medical Care in the United States." George St. J. Perrott presented the facts. Michael Davis pointed out that the need for manpower brought home to the public the importance of the health of man; and that the idea of public funds for the care of the sick was becoming progressively more popular. The real issue was: Would health departments assume more responsibility for the care of the sick? If they did not, the departments of public welfare might be forced to do so. Public health nursing must then fall in line, for after all, the care of the sick is really the fountainhead of our service.

Another event worth noting was the special conference to discuss "The Education and Employment of the Negro Public Health Nurse." This was the first time a special session had been devoted to educational and employment opportunities in public health nursing for Negro nurses.

An interesting discussion arose at the last N.O.P.H.N. business meeting which

brought out that public health nurses the country over are being asked by the citizenry why they do not join the armed services. They are at the same time encouraged by their agencies and by their national organizations to remain on the job, to help safeguard civilian health. The community at large no doubt wonders why public health nurses—especially those not giving bedside care—are urged to remain at their posts. Private duty nurses and general staff nurses in institutions, on the other hand, are encouraged—nay urged—to join the forces. Are the needs of sick civilians less important than the needs of the healthy? These are challenges we must face. High sales pressure has been brought upon the public to convince it of the nation's needs for more nurses. Naturally, they think in terms of needs for the armed forces. Can we as successfully sell the public the idea that the civilian population outside of hospitals also needs nursing service?

Then too, we wonder about public health nurses who give no bedside care; others, who because of the large areas they cover, feel they merely skim the surface; and still others, who work in communities where five or six agencies offer public health nursing services. Is it any wonder that these public health nurses might feel their services would not be greatly missed? How can they justify the need for their services to the communities at large? The Resolutions Committee report appears on page 411. But this question is only partially answered in that report.

The war is real. There are—and tragically enough there will be—huge casualties. The need, and the very dramatic quality of that need, naturally pull the interest of many nurses. Until every public health nurse believes she is giving a vital service to her community and is essential to its welfare—only then will many of the younger nurses

(Continued on advertising page 8)

# Wartime Social and Economic Adjustments

By MAYNARD C. KRUEGER

"Now is the time to close the gap between the things we *do* and the things we *say* we do"—this became the keynote of the 1942 N.O.P.H.N. Biennial Convention

A DEMOCRATIC economic and political order does not work like a telephone or like an automobile. You can drive your automobile without knowing anything about the second law of thermodynamics, and you can operate your telephone and get successful results without knowing anything about the laws of electrical induction. But you cannot operate a democratic economic order nor a democratic political system and make any kind of difficult adjustments without understanding more of the basic laws of its operation than we are required to know about our telephones or our automobiles.

The problem of wartime adjustment is a complex one, but its complexity is made all the more confusing by the fact that every particular interest in the economic order invokes the war effort as its justification for whatever program it proposes. Most people continue to favor exactly the things they favored before, except that now they have one more reason; that is, it is necessary in order to win the war.

It is, then, not sufficient for people to say merely that the adjustments they propose are necessary in order to serve the purposes of victory. Everybody is saying that. What is necessary is to distinguish between truth and falsehood in that regard. The confusion which arises from the fact that everyone invokes the name of the war in support of his own particular program is particularly embarrassing to a profession like

public health, which has always been too modest in asserting either its own interest or its contribution to the public welfare, and which on the whole does not have powerful, self-interested friends at court.

It will not do merely to say that everything else must be sacrificed to the war effort. There must be a judicious selection of the adjustment policies which are to be supported or we are likely to find ourselves in the position in which the little dachshund found himself when he grew so long that he had communication troubles between his head and his tail.

## TRANSITION FROM PEACE TO WAR

If we do not want to find ourselves in that position, we must examine the major adjustments which seem to be called for by the transition from peace to war.

First, the major purpose of economic activity is altered. We have become accustomed to the notion that the major purpose of economic activity is the production of goods and services for consumption. That is no longer true in wartime. The major purpose of economic activity becomes the production of war materials. We have become accustomed to the notion that the major function of economic activity, in terms of which it must justify itself, is the popular welfare. But the popular welfare in time of war gives way to the power of the state as the major objective of economic activity. Because in



the Fascist economy the popular welfare gives way to the power of the state as the primary objective of economic activity, and because that change occurs in time of total war in any economy it becomes all the more necessary for us to examine carefully the wartime policies of our own state in order that if not on that score, at least on others there must remain a distinction between its policies and those of the Fascist state.

#### OUR WHOLE ECONOMY IS CHANGED

The change in the purpose of economic activity is accomplished—and this is the second major adjustment—primarily by the diversion of men and materials from the production of consumer goods to the production of military goods. You have all heard of the retooling of factories, the abandonment of certain plants, and the building of other new plants. You have heard of the closing down of certain industries. These industries are closed down in the war economy not in order to stop them from producing, but in order to compel the shifting of the raw materials and the manpower which had previously been used in the production of consumer goods to the production of war goods. The diversion of resources from the uses to which they were put in time of peace to the uses to which they are to be put in time of war becomes a major function of all political and economic activity.

#### GOVERNMENT FUNCTIONS INCREASE

This brings about a third major change—a change in the method by which the economic system is coordinated. We have become accustomed to the notion that an economic system hangs together rather automatically. The producers of a commodity do not meet the consumers of that commodity directly in any place. They sell through wholesalers and jobbers, and eventually, through retailers, so that by a long market process producers and consumers

are in very indirect and impersonal communication with each other. However, that automatic process of coordinating the economic system through the market is not equal to the strains which are thrown on it in time of rapid change. It therefore gives way to a deliberate, administrative process of coordination.

That means that the functions of government tremendously increase; it means that the functions of the private businessman rapidly decrease. Before another year has gone by, in all large scale business in the United States the government will be determining the type of product to be produced, the detailed specifications for that product, and the scale of output for the corporation. It will be regulating the selling price of the product, and most of the costs of production. Most of the functions, then, which have been the functions of the private enterpriser in business pass over into other hands and become temporarily or permanently the functions of governmental authority.

In the field of labor also a substantial change takes place, for as boards of directors are brushed aside and governmental agencies take over directly the coordination of the economic system, labor does its dealing more directly with the government than with the private management of industry. This alters labor's role in the entire economic and political process.

#### CONSUMERS ARE VOICELESS GROUP

There is also a change in the role of the consumers, although I wish there were more to be said about this subject than there is. The consumer becomes no longer the person who by buying in the market determines indirectly what should be produced. He becomes merely the recipient of what is left after all that can be diverted to the production of war materials has been diverted. The consumers on the whole remain the

most unorganized interest in the entire scheme. The industrialists are strongly organized. Labor is rather strongly organized. Professional people are organized, not strongly, but rather numerously, in a genteel and mild kind of way. But the consumers on the whole are the great voiceless function in the economic order, paying no attention to the direction in which the economy develops, speaking up neither in their own interest nor in that of the public of which they constitute so large a part.

As a result of these changes in the controls of the economic system and the substitution of governmental coördination for the automatic coördination of the market process, there is an intensified argument about who should have just how much to say about the control process. Labor of course demands an increasing voice in the administration of the economy. The consumers would, if they were organized as are other people, demand an increasing voice. The conflict element in the economic order is likely to be on the increase as against the elements making for harmony. There is a small total national product in terms of consumer goods to be divided for the support of the entire population. This shrinkage of available consumer goods necessarily brings an intensified argument about how that smaller total is to be divided among a population which remains as large as it was before.

#### WHY PRICES INCREASE

A fourth major adjustment in the transition from peace to war flows again from the diversion of men and resources. This diversion raises price problems and tax problems, and makes it vitally important to understand the relationships between "standard of living," "taxation," "borrowing," "cost of living," "inflation," and "price controls."

When resources are diverted from the production of consumer goods to the production of war materials, necessarily

the quantity of consumer goods available to people becomes smaller. There is a reduced output of automobiles, of refrigerators, of washing machines, of vacuum cleaners, and of dozens of other less spectacular gadgets on which we have become dependent. This reduction in the output of consumer goods will bring about certain inevitable consequences in the monetary field unless certain things are done. That is, if people go into the market and try to spend the same amount of money which they have been accustomed to spending for consumer goods, and if there are only half as much consumer goods available as there were before, the consumers will bid up the prices of everything, and the price level will be doubled. If we try to spend the same old amount of money on half the volume of goods, then prices go up to twice what they were before. This is the basic relationship between the reduction in the output of consumer goods and the cost of living.

#### TAXATION PREVENTS PRICE RISE

The tax problem flows basically from the fact that the output of consumer goods is being decreased. If you want to prevent prices from rising in general—and a general price rise is all we mean by inflation—and if there is a reduction in the output of consumer goods, then the thing to do is to reduce the amount of money which people are able to spend for consumer goods. The simplest, most direct, most straightforward method of accomplishing that end is for somebody to reach into people's pockets and take that money out before they get a chance to spend it. Now, you do not have the power to do that, and I do not have the power to do that, but a government does have the power to do that by means of taxation. Taxation then becomes the major device by which people are prevented from trying to spend more money on consumer goods than there are consumer goods available for them to buy.

Taxation becomes a deliberate means of getting money out of people's pockets before they get a chance to try to spend it on goods that are not there because the resources have been directed to war-time uses.

#### GOVERNMENT BORROWING

There is one other method of accomplishing that same objective. It is not such a good method, not too dependable, and not so straightforward, but therefore politically more popular. That is the method of borrowing. A government says to its citizens: "If you will spend your money for bonds instead of for the goods that are not there, you will get the bonds and you will still not get the goods that are not there. But you would not have got them anyhow, so by buying the bonds you merely avoid wasting your money bidding prices up." However, on the whole people do not believe that argument.

In general, our experience with war-time finance is that the dependence has to be primarily upon taxation rather than upon borrowing. So far as the cost of living and the standard of living are concerned now, it makes no difference whatsoever whether a person gets a tax receipt or a bond in return for the money which he surrenders. It does have some significance later when the question of repayment comes up, but not so far as the immediate process is concerned.

If the sum total of taxation and borrowing is not equal to the increase in public expenditures on military goods, consumers do go into the market and try to spend more for goods than there are goods available at the old prices. As a consequence, the prices go up. A rise in the cost of living, then, is a measure of the failure to adjust taxation and borrowing, primarily taxation, to the decrease in the amount of available consumer goods. The extent to which a government feels itself compelled to rely

on general and direct price controls is also a measure of the extent to which it has failed to solve the problem by raising the tax bill.

From the standpoint of the price control problem and from the standpoint of the inflation problem, or the rise in the cost of living, this conclusion is inescapable: What this country needs is either a smaller military program or a larger tax bill. For if we try to maintain a military program of this size on the basis of a tax program of the size which is now being discussed in the Treasury or on Capitol Hill, the inevitable consequence will be a further continuation of the rise in the cost of living which has already flowed from exactly that same situation.

#### COST OF LIVING HAS INCREASED

During the year from March 1941 to March 1942, the price of food on the average rose 23.1 percent; the price of clothing, 17.3 percent; the price of coal, 7.2 percent, and the price of housing, 3.4 percent,\* not counting the increases in rents since March. Every major item in the ordinary man's budget except gas and electricity has gone up in price. That price rise is a measure of the failure of the tax program to be sufficiently great; that is, it is a measure of the discrepancy between the increase in the governmental purchases of military goods, and the decrease in the people's purchases of other goods.

These increases in the cost of living continued during the month of March.\* In March 1942, the price of men's clothing on the average throughout the country increased by 1.7 percent; the price of women's clothing, 1.6 percent; the cost of living in general, 1.5 percent. This varies, of course, in different parts

\*Bureau of Labor Statistics, United States Department of Labor. "Cost of Living in Large Cities, March 1942." *Monthly Labor Review*, May 1942, page 1170.

of the country. In Los Angeles during the month of March, the average price of food was up 2.9 percent; in Scranton, Pennsylvania, the same; in Kansas City, 3.4 percent. It increased 4.6 percent in Mobile, Alabama, where the price of milk went up three cents a quart in March in a city where a large proportion of the population already was not getting enough milk to maintain a decent kind of diet.

This, then, is a gradual inflation at a rate which exceeds one percent per month, and which, unchecked over a long period of time, will become a very substantial kind of inflation. For most people the increase in the cost of living has exceeded the increase in taxation. For most people the measure of their economic sacrifice for the war effort is not the extent to which they pay a tax bill, but the extent to which they pay the increased cost of living.

#### HOW PREVENT INFLATION?

The alternative to inflation is then fairly clear. One possible alternative, of course, to which little attention is paid, is increased production of some commodities. In a city such as Mobile, Alabama, what is called for is not more taxation to keep the price of milk from rising. A larger amount of milk must be made available to the people of that region regardless of price. An increase in the amount of certain basic consumer goods is necessary from the standpoint of health and social objectives. However, it still remains true that the basic alternative to inflation is either more taxation or a compulsory borrowing which will be so much like taxation that people will not be able to tell the difference.

Now, if taxation is better than inflation—and I have not gone into the argument as to why taxation is preferable to inflation—why do we have inflation instead of having more taxation? The answer is a very simple, political one. If there is to be greatly increased

taxation for the avoidance of inflation, some administration must propose the increased tax bill, and everybody will know which it is. Some congressmen and senators must vote for the bill. It will be a roll call vote, and everyone will know who does it. People who are themselves enthusiastic about the war and salute the flag for breakfast, lunch, and dinner may still vote against a congressman who votes for the kind of tax bill which would finance that war without inflation.

The political advantage of inflation is that nobody needs to propose it, and nobody needs to vote for it. Taxation must be deliberate, but inflation comes like a thief in the night and nobody knows where it comes from. Nobody needs to beckon to it, and there is no roll call vote at any point, but it accomplishes the same objective in a worse way. People are not going to be able to get the goods that are not there. But if they try to spend their money on goods, they will spend all they have and they will not get any more goods than there are there anyhow. And so inflation is a kind of deserved dirty trick which is played on people who either did not have the sense or the courage or the vision to realize what the tax bill was for a war program of any certain size.

#### WHO SHALL BE TAXED?

Of course, this tax question raises questions of social policy, and I would like to make a brief reference to this problem of social policy in the taxation field as a fifth major wartime adjustment. If there is to be increased taxation, whence comes the increased tax revenue? Whose standard of living shall be cut, and how much?

The lowest one-third of the population in the United States gets about 11 percent of the national income; the middle third of the population gets about 24 percent, and the highest third gets 65 percent. The highest third includes almost

all of the middle class as we define the middle class in popular terms in the United States. Everybody with an income above \$1800 or \$2000 a year is in the upper third of the income distribution of the country.

If the purpose is to divert one half of the resources to the war economy, I leave you the question. Out of 11 percent which goes to the lowest third, 24 percent which goes to the middle third, and 65 percent which goes to the upper third, where do you get 50 percent to divert to the war economy? It is quite obvious that almost all of that 50 percent must come from the upper third. Maybe some small amount of it can come from the middle third. None should come from the lowest third, consisting of people with incomes below \$900 a year. Every dollar that is taken from that third of the population by taxation must be replaced through some kind of public benefits.

The program should therefore call for neither taxation nor borrowing from the people in the lower third of the income scale, who earn below \$800 or \$1,000 a year. It should call for a heavy tax program on those in the upper third, above \$1800 or \$2000 a year—and the program should be taxation and not borrowing from the upper end of the income scale. Whatever is taken from the people in the middle third between say \$900 and \$1800 a year, should be by borrowing. That is, the people in this income group should be given redeemable receipts rather than unredeemable receipts in order that the war program may not make worse the distribution of wealth which was already so inequitable in the United States that a large proportion of the population simply was not able to maintain a decent standard of living.

#### THREE DANGERS TO BE AVOIDED

In this situation there are of course a number of dangers, three of which I want to mention. One danger is the

siren song which we hear from certain congressmen: "Let us reduce the government's non-defense expenditures." The argument that all non-defense expenditures should be cut out is an argument that a country should pay no attention to the purposes in the name of which it is conducting a war. Furthermore, the non-defense expenditures of the Federal Government are quantitatively insignificant. They account for about six billions alongside a military expenditure which will probably reach seventy billion dollars during the coming fiscal year.

Another danger is that of political centralization. There is inevitably more political centralization of power in the operation of a war economy. But because that increased centralization is inevitable, we must give more attention than ever before to the building of what I like to call the "functional organizations of the people"; that is, organizations of people who perform a certain function in the economic system. It may be a labor union; it may be a public health nursing organization; it may be a teachers' organization. Unless these organizations are strengthened, there is nothing in the way of a democratic locus of power to set against the inevitable tendency toward increased governmental centralization of power.

If in the operation of a war economy you want to prevent a government from going totalitarian, one thing you must do is to strengthen the functional organizations in which people are directly represented and in which there is rank-and-file control. This country needs more, not less, of that kind of organizational strength at the base of the politico-economic pyramid.

A third danger ever present in an emergency situation is that at every turn of the road, long-run considerations will be sacrificed to meet short-run considerations. There are enough people in this country who put their emphasis entirely



on the short-run, emergency situation, and there are not enough people representing the long-run point of view. From the long-run point of view, it will not be the handling of emergencies that will determine the character of the social order of the future under which we are going to live.

#### THE THINGS WE SAY WE DO

Two very important challenges are found in this situation. One is to do a thing which has never been done in any other country in the Western world, and for failure to do which democracy has been put on the defensive. *Now is the time to close the gap between the things we do and the things we say we do.* The things we say we do, in the Declaration of Independence, in Fourth of July orations, in sermons from the pulpits on Labor Day Sunday, are better than the things you can hear said in any other country in the world. But the gap between the things we say we do and the things we do is so great that—as has happened earlier in other countries—millions of people are inclined to turn their backs on the rhetoric of democracy, finding it insufficient for their lives. The slogans which used to ring the bells in men's hearts will no longer ring the bells unless some real content be put into them.

We talk about race equality; we talk about equality of opportunity; and we talk about economic democracy. But the divergence between the slogans and the things we do gets us, as it got the German Weimar Republic, into jams worse and worse as the days go by. This calls for some bold strokes. It is not enough in these matters merely to move in the right direction. Anybody can move in the right direction, but moving in the right direction by slow steps is the best way in the world of falling off your bicycle. If you have ever learned to ride a bicycle, you know it is not enough to move in the right direction,

taking it very slowly and saying, "Until we get a great deal of experience now, we are not going to go fast enough to take any chances. We might fall off if we went too fast."

#### BOLD STROKES ARE NEEDED

A social order does not fall off its bicycle going too fast; it falls off going too slowly. That is what the Weimar Republic did. It moved in the right direction so slowly that it could not stay on its bicycle. That is what we are doing today, moving in the right direction so slowly that we cannot stay on the democratic bicycle. We need bold strokes in the field of equality of opportunity, in the field of racial equality, in the field of providing equal access to all the basic facilities of life in the midst of peace or in the midst of war. If it is more difficult to do those things in the midst of war, then we face that difficulty only because we did not do them in the midst of peace. We do not thereby escape the obligation to do them even under the more difficult circumstances.

#### CONSERVE OUR HUMAN RESOURCES

A second challenge which is provided by this situation is one which lies in the field of conservation of assets. We hear a great deal about conservation and building up of material assets. We know that the oil supply is being depleted, that the forests have been cut down. Some attention has been paid to the conservation of material resources. But the basic things out of which the welfare of a people are made are three and not one—not merely material resources, but material resources, technology, and human resources.

Material resources will suffer inevitably on account of the war. That we might just as well face. Technology in all likelihood will make some rather substantial advances in the course of the war. But the problem on which attention must be lavished is the problem of

the conservation and development of human resources. This becomes primarily a twofold matter—a matter of health and of education. Increasingly health is necessarily a matter of public health, and increasingly education must be a matter of real public education rather than merely the kind of education which is the handmaiden of private industry, teaching people how to do this and that which they are going to do later in an occupational way.

We must have more of public health and more of the kind of public education which devotes itself to public purposes. This is the joint front on which public health and public education work directly together. Both public health and public education assert the individual worth of man and the interdependence of mankind. Interdependence and individuality of human beings need more and more emphasis these days even in the midst of war.

If I were proposing a quotation which

might be put at the head of an address like this, or at the end, I would take the one from John Donne which Ernest Hemingway thought worth using on the flyleaf of his novel, *For Whom the Bell Tolls*:

No man is an *Iland*, intire of it selfe; every man is a peece of the *Continent*, a part of the *maine*; if a *Clod* bee washed away by the *Sea*, *Europe* is the lesse, as well as if a *Promontorie* were, as well as if a *Mannor* of thy *friends* or of *thine owne* were; any mans *death* diminishes *me*, because I am involved in *Mankinde*; And therefore never send to know for whom the *bell* tolls; It tolls for *thee*.

In every failure in the field of public health or in the field of public education, whether it affects a colored man in the South or a factory worker in the North, in every failure to do what we say we do—"Never send to know for whom the bell tolls; it tolls for thee."

Presented before the N.O.P.H.N. General Session, Biennial Convention, Chicago, Illinois, May 19, 1942.



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# Can We Produce Enough Food?

By ORIS V. WELLS

America's food needs today, our present supplies, and the Department of Agriculture's program for meeting the needs are described by its chief program analyst

**T**HE SUPPLY of food in the United States for 1942 is expected to be the largest on record. This means, of course, that we will have adequate supplies for domestic consumption and that in 1942 Americans will again be the best fed people in the world.

However, once we go beyond this simple summary we must face certain facts. Our generous supplies must be divided with our Allies. Far too many of our own families are ill-fed. Shipping shortages, efforts to conserve scarce supplies and services, and price controls are conditioning the food supply and the manner in which it is distributed. Finally, our farmers have a real job ahead if production is to be maintained or increased, as it must be in 1942 and 1943.

We have been accustomed to talking in terms of agricultural surpluses. But now everyone realizes that food is an all-essential weapon of war. The need for maintaining or increasing food production is becoming clearer every day, and American farmers are now engaged in an all-out effort to see that food supplies are increased.

#### FOUR NEEDS FOR AMERICAN FOOD

The Secretary of Agriculture recently said that there are four great needs for American food in this war, and it may be added, for oil crops, and to a certain extent, for other farm products such as cotton.

First and foremost, there are our

soldiers and sailors. Of course, these are able-bodied young men who were consuming substantial quantities of food before they entered the Army and Navy, but the average soldier eats more than the average civilian. The troops in expeditionary forces and those guarding our bases in this hemisphere also have special food requirements. We must supply distant troops with a large part of their rations from this country, and much of these rations must be concentrated to conserve shipping space. This means increased demand for dried milk, dried eggs, and dehydrated fruits and vegetables, as well as other types of processed foods that have not been so important in the past.

Second, come the requirements of the other nations with which we are allied. Our own needs for concentrated foods are small compared to the requirements for lend-lease shipment. We have undertaken to supply the British with one-fourth of their protein. Although the actual amount of food sent is not so large a percentage of the total food they eat, the shipments are in concentrated form and mean a greatly increased demand for dried eggs, cheese, condensed and evaporated milk, canned meat, and lard. The British people depend upon us to keep food moving. Russia needs our food, as well as our munitions, and food shipments to Russia are now reaching a considerable and increasing volume.

Third, there are our own needs for domestic consumption. A greater num-

ber of people in the United States are working than ever before, many at longer hours and at greater rates of speed. Our own demand for food is increasing because more work is being done and more food is needed. It is increasing because more families are obtaining incomes which will allow them adequate diets. All of us realize that the maintenance of a well fed population is essential to the successful continuance of the war effort.

And finally, we are increasingly convinced that we must build larger food reserves in order to meet any contingency that may arise during the war, and in order to have food on hand which can be used in the rehabilitation of over-run countries and exhausted populations following the end of the war. Food reserves are not only essential to the war effort; they will be an important factor in shaping the peace.

All these demands for farm products add up to just one thing: we need all the food we can get. American farmers must produce more than ever before, and American consumers must ensure that waste is avoided and that the needed scarcer foods are conserved. There is enough food, but we must see that it is equitably distributed and wisely used.

#### CAN WE SUPPLY IT?

As has been indicated, the supply of food in the United States for 1942 is expected to be the largest on record. Stocks on hand at the beginning of the year were at record level. Crop acreages will be somewhat greater than last year, especially for those crops most needed. So far, weather conditions have been rather favorable, and conditions of crops in most sections of the country at present are very good. The numbers of livestock on farms also are almost all at record level.

Wheat is the most important grain used for direct human consumption. We

will have a carry-over of old wheat at the end of this crop year sufficient to supply our needs for an entire year ahead, with an 800,000,000 bushel new crop in prospect.

With respect to rice, farmers have indicated their intention to increase acreage by at least 15 percent over 1941. Although we are shipping greatly increased quantities of rice to Cuba due to the stoppage of Oriental supplies, we should have enough rice to supply both ourselves and Cuba.

Only a small portion of our corn crop is used directly for human consumption, but it is by far the most important feed grain. We will have large stocks of old corn on hand this fall, and farmers will increase corn acreage by about five percent, and maintain or increase their acreage of oats, barley, and grain sorghums—the other grains which with pasture and hay are used to feed livestock.

The number of hogs on hand at the start of 1942 was considerably larger than in 1941, and larger than for any year since 1933. The new pig crop is expected to surpass last year's, and probably the number of hogs slaughtered under federal inspection in 1942 will surpass every year except 1924. This means more pork and lard. However, purchases of pork and lard for lend-lease shipment are being rapidly increased, and as a result, the supplies available for domestic consumption will of course be reduced and may be no larger than they were for several years prior to 1940.

Fortunately, larger supplies of beef, veal, lamb, and mutton are in prospect, and the total of all meat supplies for domestic consumption in 1942 will apparently be at least equal to that available during 1940. Cattle numbers have been increasing for several years, and we can now increase marketings for slaughter, without sacrificing our livestock supply. Sheep also have increased in recent years, and their number is now at a

relatively high level. It may be added that we also need all the wool we can produce.

The number of chickens now on farms is large enough to meet the egg production goal for 1942, which is 13 percent above the record output in 1941.

Milk cows on farms have been increasing during the last several years, and milk production was at a record level in 1941, and is currently running about four percent above 1941. The production of cheese, evaporated milk, and dry skim milk have all been stepped up at a rapid rate in order to meet increasing lend-lease and Army demands.

Production of fats and oils from domestic materials in 1942 is expected to be a billion pounds greater than in 1941, but imports of fats, oils, and oilseeds in terms of oil, which in recent years have varied from one and a half to two and a half billion pounds annually, may be much smaller than in 1941. At the same time, the demand for fats and oils is at a high level and we must conserve our supplies or stocks will be materially reduced during 1942.

As to fats and oils used primarily for food, the domestic oil production in 1942 should be well above that in 1941. Cottonseed oil, peanut oil, soybean oil, corn oil, edible beef fats and oils, and lard will all be increased. Butterfat available for butter will be sufficient to meet the current demand.

Rationing of sugar has been necessary because supplies from the Philippines and Hawaii have been cut off, and because considerable Cuban sugar is being used to make alcohol. In 1942 sugar production in the continental United States, and in Cuba and Puerto Rico, two important areas normally supplying the United States with sugar, will probably be well above that of recent years. Some of the available sugar, however, will go to our allies, and we must continue to conserve our sugar supplies in the year ahead.

Supplies of vegetables and fruits in 1942 will probably at least equal those of last year. Marketing these crops will be the real problem in some areas.

A new record pack of canned vegetables is called for in 1942, with an increase of about one third in canned peas, and one fourth in tomatoes, with most other vegetables about the same as in 1941. A very considerable volume, however, will be required for our armed forces and for lend-lease shipment. To some extent, the tin restrictions made by the War Production Board will also affect the supply. The use of tin for containers for products which can be preserved by other means has been prohibited—for example, dry beans and peas, spaghetti, cereals, flour, coffee, spices, and condiments. A general thinning of tin plate coating is also required, and small-size cans have been eliminated.

To summarize, an analysis of food supplies relative to the demands now in sight indicates a per capita supply of food in the United States for the year ahead, about equal to the average supplies which we disposed of during the five-year period 1936-1940. Per capita food consumption in 1941 was at a record high level, and the average consumption in 1936-1940 was as high as during any five-year period since World War I. We may not be able to maintain the high level of consumption which prevailed during 1941 in the case of every food and class of food, during the year ahead. But there will certainly be enough food to maintain our present nutritional level and to give every person in the United States a reasonably good diet provided our supplies are conserved and equitably distributed.

From a nutritional standpoint, although our volume of food is large, it will still not provide as much calcium and certain vitamins, especially thiamin and riboflavin, as is considered desirable for an "ideal" diet. But the supply of



these food elements in the United States has never been sufficient for this. Moreover, it is true that a great many families in the United States are sadly in need of better diets. Perhaps the diets of many of these families can be improved despite the war, because increased incomes will allow the purchase of reasonable amounts of food for the first time in several years. And if certain foods run short, rationing can be used to assure an equitable distribution.

#### THE AGRICULTURAL PROGRAM

These statements have assumed, of course, that we are to have normal yields, and that farmers will be able to obtain the necessary labor and equipment in 1942. Farmers themselves are faced with many problems if production is to be maintained, and there are a number of difficult questions relating to processing and marketing facilities which will have to be answered.

But I am certain that the farmers will find answers to most of these questions, and that the food will get processed and marketed. Since the beginning of the war, the Department of Agriculture has been shifting its programs, in order to help farmers maintain and increase production, and to assure the most effective utilization of the food materials produced.

After our entry into the war on December 7, production goals were completely revised. Stated in one way, these goals call for a production sufficient to maintain normal per capita consumption of most foods and foodstuffs, as well as the necessary allowances for lend-lease shipment, and in a number of cases for increases in reserve supplies as insurance against contingencies of the war and drought. Stated in another way, these goals call for the maximum agricultural production, of which the farmers of the Nation are capable, in 1942.

As compared with 1941, these goals called for a 7 percent increase in milk,

a 13 percent increase in eggs, a 10 percent increase in chickens, a 14 percent increase in hogs, an 8 percent increase in corn, a 6 percent increase in rice, a 13 percent increase in dry beans, a 32 percent increase in canning peas, a 27 percent increase in canning tomatoes, a 54 percent increase in soybeans, a 155 percent increase in peanuts, and an 8 percent increase in the number of cattle and calves marketed, as well as a substantial increase in the number of farm gardens and the maintenance or increase in the acreage or production of almost all of the crops except wheat. Supplies of wheat on hand were so much in excess of the amount which could be used that it seemed desirable to reduce wheat in order that the acreages of other crops might be increased.

#### ASSURING FARMERS OF MARKET

Simultaneously with the announcement of these goals, the Department of Agriculture stated that it would support, at 85 percent of parity or above, the prices of certain commodities for which increases were most needed, in order to assure farmers of a stabilized market. Price supports were announced for hogs, eggs, evaporated milk, cheese, chickens (excluding broilers), dry field peas, most varieties of dry edible beans, peanuts, soybeans, and flaxseed for oil. Additional price supports on a somewhat different basis were announced for potatoes, canning peas and tomatoes, and a number of other vegetables for canning. The Department is working with war agencies to see that necessary equipment and supplies are made available to farmers, and with the United States Employment Service to see that efficient use is made of farm labor.

Despite the labor situation—and of course, Selective Service and defense employment are pulling many workers away from the farmers—and despite the fact that many essential farm supplies are available only on a limited scale, we

believe that farmers will meet the goals for 1942.

In addition to encouragement of production, the Department of Agriculture has developed its marketing and other programs in order to obtain maximum utilization of food in 1942. The school lunch program, under which food is made available to cooperating communities for free school lunches, is being continued, and if Congressional appropriations are authorized, it will be possible to expand the program further during 1942. At the present time it is estimated that six million children are being reached. The food stamp program, under which families on relief rolls are given free stamps to enable them to increase their purchasing power for foods by 50 percent, will be continued.

In conclusion, may I repeat, we are now engaged in a war, and food is an essential war material. The farmers in the United States are engaged in an all-out production effort, and the Department of Agriculture has endeavored to shape or reshape all its programs in order to help farmers in this effort. Given reasonable weather, food supplies available for domestic consumption in the year ahead apparently will be about

equal to the supplies available during the five-year period 1936-1940. Supplies of some foods will be relatively scarce and measures to conserve such foods will be needed. For some foods, rationing may be the only means by which an equitable distribution can be assured. But there is no need to fear that we will not have enough food to supply all our people with a reasonably adequate diet and to supply our allies with increasing quantities of needed foods, not only in 1942 but in the years still further ahead.

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## Newer Treatment of War Injuries

ENGLAND at war and the treatment of bombing victims were graphically pictured by Dr. Philip D. Wilson at the N.O.P.H.N. opening General Session on May 17. Dr. Wilson is surgeon-in-chief of the Hospital for Special Surgery, New York, N. Y., and medical director of the American Hospital in Britain. A report of his talk follows:

High explosive bombs varied in weight from one hundred to one thousand pounds. Those of two hundred and fifty pounds were most easily carried by planes. This type of bomb produced a great crater where it fell and its explosive effect extended over an area of a block. The explosion occurred only after penetration, and because of the initial pressure of gas and ensuing vacuum created, windows were blown both in and out. The crater might be as wide as a street and twenty-five feet deep. The blast was felt at a great distance and people might be killed by the blast alone, without external wounds. The time bomb was also a high explosive type but with delayed action. Explosion might be delayed as long as a week or more. As a result the effect was highly demoralizing to the population. Both of these types of bomb were directed at a target.

The land mine was a large explosive type fastened to a parachute and could not be directed to a definite target. It went off before it touched the ground. The effect of the explosion was horizontal in direction.

The incendiary bomb showered small incendiaries—as many as two hundred—over a large area before reaching the ground. Sometimes drums of gasoline were dropped over them from planes to increase their incendiary effect. Small explosive bombs were mixed with in-

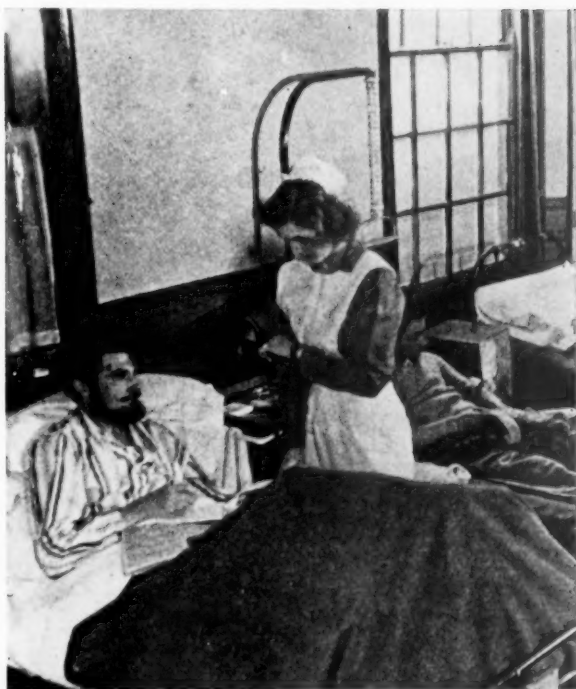
cendiary bombs. The regular incendiary bomb could be put out but the addition of the explosive bomb obviously complicated the situation.

Secondary missiles as well as parts of bombs were often responsible for injuries. Many injuries were also caused by the collapse of buildings. Dr. Wilson commented upon the efficiency of the wardens and other volunteers who appeared upon the scene quickly after notification of headquarters by the A.R.P. Ambulances were sent to transport the injured to areas of safety. Since some of the ambulances were destroyed in transit, the question naturally arose as to whether it was not better to shelter the wounded until the raid was over before moving them. The difficulties of working in the dark, during night raids, were also described. Only small flashlights which gave off very little light could be used.

After the air raid, victims were transported to hospitals by ambulances. They were taken to underground emergency or reception centers in the hospital where the stretchers were placed on trestles. Experienced surgeons served as reception officers, since great judgment was required in determining what plan of treatment was to be followed and the decision had to be reached after a rather hasty examination. Treatment was prescribed depending on the type and severity of the injury. The patients were then designated for (1) treatment of shock (2) surgical operation after x-ray examination, or (3) dressing and observation and return to their own homes.

Shock was reported to be very prevalent. Often the patients were on the verge of shock when they arrived at the reception centers and major shock might be precipitated by surgical oper-

An American nurse, serving in the American Hospital in Britain, cares for her patients—casualties of war



ation. It was, therefore, a dictum among surgeons not to operate if there was any question of shock. The victims of the raids received treatment in "shock rooms" staffed by special teams and equipped with special facilities. Intravenous injections and blood transfusions were administered. Dr. Wilson particularly commented on the fact that the administration of citrated blood and plasma was very well carried out in England. The blood depots were well supplied. Citrated blood was issued only for a week at a time and was then converted into blood plasma.

After the patient's recovery from shock he was taken to the operating room where treatment included debridement of his wounds to eliminate foreign bodies and infected and contaminated tissue; packing of the open wounds with vaseline gauze; the use of chemotherapy—both local and general—in some instances; fracture reduction by the use

of traction and pins; and application of a closed plaster cast.

About sixty percent of those entering the emergency centers had injuries of the extremities, the majority of which involved the bone. Dr. Wilson said compound fractures were numerous. The method and advantages of the closed plaster treatment and the use of chemotherapy both by mouth and by application to the wound were explained with accompanying colored moving pictures.

After the emergency treatment described above, the patients were ready for evacuation to safer areas, where they were kept until recovery. The policies and procedures in effect in the emergency centers were different from those adopted by the base hospitals.

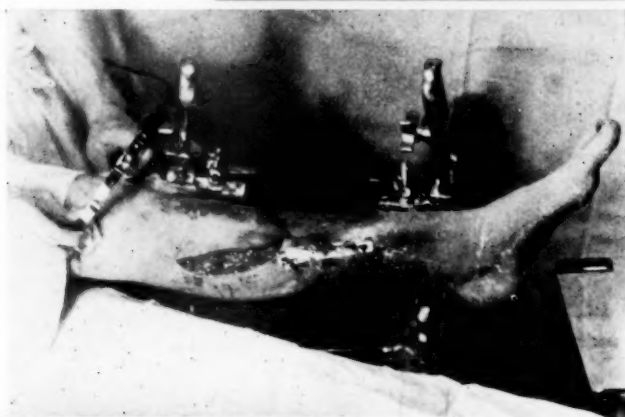
The care of the patients at the Park Prewett Hospital was fully described. The American Hospital in Britain, of which Dr. Wilson was a member, was



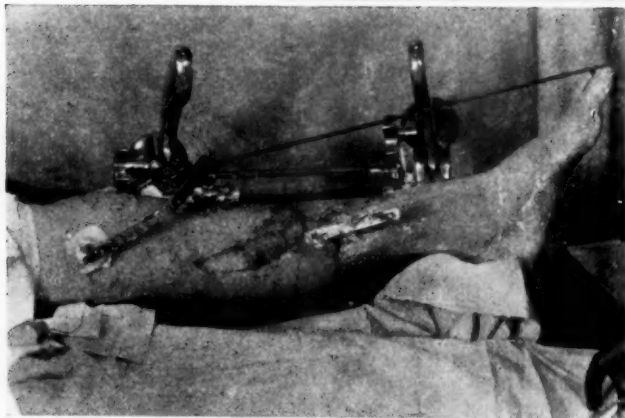
1. Compound fracture of both bones of leg showing a large wound



2. Closed plaster treatment of the wound with the fracture reduced and held by skeletal pins



3. Position of fracture being adjusted. Wound closed by plastic flap



4. Remaining wound closed by a skin graft—patient on the road to recovery



located here at first. The patients came usually from a few days to a week after injury and were checked up in regard to their previous treatment. X-rays and surgical notes were studied. Most of the patients arrived with closed plaster dressings. Next steps in treatment depended on certain symptoms. Fever was not accepted as a reliable symptom of the patient's condition. Pallor, loss of appetite, rapid pulse, and pain were all taken into account, but of all these symptoms pain was considered the most significant. Plaster was not removed to satisfy surgical curiosity as to the extent or condition of the wound. If infection was thought or known to be present, the patient was taken to the operating room for retreatment. Sometimes the plaster was found to hold the part in poor alignment.

Dr. Wilson emphasized the fact that the importance of the closed plaster method of treatment had been recognized by all doctors in England treating war casualties. Its benefits:

1. The saving in labor of medical and nursing personnel.
2. The saving of materials.
3. The saving of pain to the patient.
4. The better progress of healing.

The use of the Carrel-Dakin method during the first World War was referred to as a great advance at that time. This method involved daily dressings which required tremendous amounts of medical time and labor, not to mention materials. Also it involved frequent handling of the limb, which interfered with healing and caused the patient great pain.

In treating the wound according to the methods now utilized and described by Dr. Wilson, an anesthetic was administered for removal of the plaster, thus eliminating pain. The comfort of the patients was particularly stressed by Dr. Wilson, but he also referred to the fact that the foulness of odor resulting from the closed plaster treatment was



The patient is soon up and around in plaster

often a source of considerable distress to the attendants. Apparently the patients themselves were little bothered by the odor. Charcoal bags were sometimes placed over the plaster at the site of injury to help absorb the odor.

The closed plaster cast was left undisturbed for as long an interval as the surgeon felt advisable. This might be four to five weeks, or longer, depending on the condition of the patient and the integrity of the plaster. When at length the cast was removed for inspection and dressing it was done in the operating room and aseptic precautions were faithfully observed. These wounds healed from the bottom and although epithelialization was often delayed because of the irritating effects of the constant discharges, the top layer of granulations could be excised and skin-grafting operations performed. The limb was put back into plaster and in ninety percent of the cases treated the results were successful.

Reasons for the success of the closed plaster treatment were given as follows:

1. Rest is provided, and rest is required for all repair, whether due to injury or general disease.

2. Cross-contamination and secondary infection of the wound are avoided. Dr. Wilson believes that not enough importance has hitherto been attached to the prevention of infection in surgical wards. For instance, blankets are full of bacteria which can readily be spread from bed to bed, to a distance of twenty-five to fifty feet. This is a hazard if bed-making in the wards is going on concurrently with dressings. Dressings should be done only in the operating room.

3. Pressure exerted over the wound by the plaster dressing keeps circulation in better condition, preventing edema and hastening healing.

Chemotherapy had proved a great boon in the treatment of war injuries. It was considered by Dr. Wilson to have transformed surgical technique. Sulfathiazole diluted with sulfanilamide, was applied by blowing with insufflators which were said to be an improvement over the former method of "dumping" the powdered drug into the wound.

The work of the American Hospital in Britain which Dr. Wilson directed was described. This organization was incorporated in June 1940, under the laws of the State of New York, a necessity under the federal Neutrality Act, and was also registered under the Department of State. Financial support throughout the period of its operation was generously provided by the British War Relief Society. The personnel of the first unit to go over comprised seven physicians, five of whom were orthopedists, one a plastic surgeon and one a general surgeon; three nurses; and two secretaries.

The unit arrived in London on September 7, 1940, on the evening of the first great German air raid. The ap-

pearance of the fires that were caused by the first raiders and experiences during the bombings were vividly described by Dr. Wilson.

The American Hospital unit first moved into the Park Prewett Hospital at Basingstoke, an old mental hospital of fifteen hundred beds, where it operated a section of three hundred beds. During the first year a total of approximately three thousand men chiefly from the armed forces were admitted to the services of the unit, and approximately twenty-five hundred surgical operations were performed. Physicians and nurses were gradually added to its staff until the total number had reached forty. English nurses joined the unit and worked under the supervision of American nurses.

In January 1942, the unit was transferred to Oxford where it occupied the Churchill Hospital, a new military hospital of six hundred beds, built on a one-floor plan, and of a permanent type of construction. The ceremony attending the opening of the Churchill Hospital by the American Hospital unit, also shown by films, was impressive in spite of the snowstorm.

Dr. Wilson spoke briefly about the work of the English nurses, comparing the public health nurses employed by the British Ministry of Health to public health nurses of the United States. The British "shelter nurse" is always on call and combines her services in the shelter with other functions in the community.

Dr. Wilson referred to the shortage of nurses in Great Britain and commended the excellent work of the nurses' aides, or V.A.D.'s.

Physicians and nurses were also assigned to areas to which civilians were evacuated in large numbers. Here they were concerned with problems of sanitation and hygiene, nutrition, maternal and child health and welfare, and services to school children.

# Public Health Nursing in the War

By MARION W. SHEAHAN, R.N.

THE mobilization of the nurse power of this country is the problem of today. Nursing care must be provided for the armed forces wherever they may be, and the nursing personnel left at home must be utilized and supplemented so that it will give needed service to all the people. Six years before we entered the last World War, in 1912, the leaders in public health nursing founded the National Organization for Public Health Nursing for the purpose of combining efforts to spread throughout the country a service which had already proved its value to a few communities. Promotion of service and maintenance of good standards were the chief objectives. Implicit was the responsibility of its membership to meet these obligations under changing conditions. That membership must also look ahead to the future, and be prepared to share in the work of reconstruction which alone can give true meaning to this World War. But the future cannot be met unless today's job is well done. That is our present problem.

It is significant that nursing as a whole is recognized by the government as an essential service in the conduct of the war. The government's interest is expressed—as well as safeguarded—through its official Subcommittee on Nursing of the Health and Medical Committee of the Office of Defense Health and Welfare Services. That Subcommittee works especially with the professional National Nursing Council for War Service; with the American Red Cross Nursing Service which is the recruiting agency for the Army and Navy by virtue of Congressional Charter; and with other federal nursing agencies.

These groups work together to provide

facts and figures, to define needs, to suggest broad programs, to outline possible methods, and to stimulate state and local professional organizations and service agencies to implement the programs. The effective guidance they have already furnished us is evidence of their leadership. They serve, too, as our representatives before government, interpreting nursing standards, nursing organization, and nursing needs. Without a doubt, nursing is united at the national level. Here is active coordination which has earned the expression of confidence by the government in the integrity of the nursing profession, for there is no thought but that the job can be left to the profession.

## FIVE MAJOR NURSING ACTIVITIES

The five major activities at present defined for us by our national leaders are well known.

### *1. Promotion of the enrollment of every eligible nurse in the First Reserve of the American Red Cross for service in the Army and the Navy*

This need is always mentioned first. Doing our full share to recruit nurses for the First Reserve is an obligation we all share because we are of the nursing profession. The 23,000 to 25,000 nurses graduated each year are potential candidates. Every eligible nurse in the country must be enrolled in the First Reserve if the needs of the military are to be met with a safe margin for future expansion in the armed forces.

### *2. Recruitment of student nurses for good schools of nursing*

As we look ahead to a prolonged emergency and to the years when more and better educated nurses will be needed, it seems wise to begin recruit-

ing additional young women now to start their education as nurses. Nurses and others concerned with this problem agree that even greater demands will be made upon nurses of the future. We are asked to recruit, in addition to the number that would normally enter schools of nursing in a year, an additional 10,000 well selected young women for the professional schools offering the best opportunities. The Federal Government in the past year appropriated \$1,250,000, plus a deficiency appropriation of \$600,000, for the preparation of nurses, and an additional \$3,500,000 has been approved by the House of Representatives and is now pending in the Senate for the year beginning July 1, 1942.

Public health nursing agencies with their long history of lay participation are in an excellent position to interpret this program to young women with both college and high school education. The understanding of the parents of young women is important. Like enrollment in the First Reserve, this is a long-term project to be purposefully pursued wherever opportunity presents itself.

*3. Development and promotion of refresher courses to draw back into active service—full time or part time, on volunteer or paid basis—every graduate nurse able to work and give service*

Again where opportunity presents itself, every one of us can encourage nurses to resume some nursing activity. Long unused skills will come back with a little practice. The largest group of these nurses obviously should go to hospitals to replace depleted staffs. Public health nursing agencies, however, have not been as active as they might be in recruiting and preparing former public health nurses to be a reserve on call. Such nurses can furnish an excellent supplementary service, the need for which has already been felt in certain agencies.

*4. The development and promotion of home nursing classes for lay groups*

*5. Organization of local nurse power and auxiliary service for civilian emergency service*

The maintenance of health through the usual public health nursing services, while it is not emergency service, strictly speaking, is part of complete civilian protection. The last two activities listed are among the major responsibilities of public health nursing agencies. It is because of them that public health nurses, though urged to enroll in the American Red Cross, have the privilege of deferment from immediate call. Their special skills are often urgently needed at home to implement intensified health protection services, and to direct and utilize to the best advantage supplementary service by graduate nurses who are not trained in public health, volunteer nurse's aides, and other auxiliary workers—paid and volunteer.

The program of activities which our national leadership has outlined must be translated into action in every community in the country according to the needs and opportunities of each area. Only at the local level can the adjustments to war conditions become effective. There may not be complete agreement as to the extent to which adjustments should go. We must realize, however, that there is a long pull ahead to the end of the war and into the period of rehabilitation. There must be awareness of certain events which are moving fast and which now have a direct bearing on the maintenance of existing services.

#### THE PUBLIC HEALTH NURSE'S JOB

Public health nurses now have more work to perform. All children should be immunized against diphtheria and smallpox so that unnecessary illness will not complicate situations if evacuation is ordered. Doctors and nurses must be free from the demands of preventable illness if they are to be ready for care of war casualties or for other emergency

service. What three nourishing meals a day can mean must be interpreted to as many homes as possible, for workers must be kept well and families must be as self-sustaining as possible. They must be helped to understand how to maintain an adequate diet under food rationing orders, and to accept the adjustments in their diets with poise and without fear. At least one member of every family must be taught rudiments of home nursing, so that they will not be entirely dependent upon professional medical and nursing services and will know how to use these services more intelligently—for skilled service will become less available as the needs of the armed forces increase. This means many classes for members of families, and also for nurses who in turn must be helped to take on part of the teaching load.

Tuberculosis follow-up must be intensified lest its incidence increase under the strains of war. All the knowledge we have must be utilized to select cases on the basis of their infectivity and to time nursing visits so that the best results will be obtained. This is no time for wasted effort, due to visits made so long after the index case has been diagnosed that the patient and family have reached their decisions on the advice of poorly informed neighbors or fearful relatives. Under such circumstances, several extra visits might be needed to re-educate the family, and visits take time and nurse power. Patients with early syphilis must be kept under treatment until rendered non-infectious.

Finally, if war action comes to this country, public health nurses must be ready to care for an increased number of the chronically ill who may be discharged from hospitals to make room for the critically injured. They will also be needed to care for those victims of warfare less seriously injured, who will be treated at home. Nurses may be needed in the hospital or in the field, and plans should be made for flexibility

in assignment during emergency periods. Add to these demands the provision of nursing care and health supervision for evacuees—particularly mothers and children—and we have a picture of the need for public health nursing as it is today with the war just begun.

Yes, public health nursing will take on new meaning with increasing war demands. There will be fewer nurses to do a bigger job. There will be fewer cars, less gasoline, less equipment, more nursing with fewer qualified public health nurses. Our boasted ability to improvise will surely receive much practice. This picture is not overdrawn or intended to alarm or to be dramatic. It is a situation which is daily growing more evident.

Public health nursing under war conditions means accepting all related facts and so managing that the community is served. The answer is contained in all that is involved in meeting the far-reaching problem of supply and distribution of personnel and service. This all-inclusive problem is identical with that which is being met through the procurement and assignment plan of physicians. Possibly each profession may feel confidence in the accuracy of the major emphasis since both have arrived at the same definition of the major problem.

#### OUR PROGRESS TO DATE

There will be no disagreement with the statement that public health nursing operates through a group of agencies, each for the most part doing a good job with its small segment of the public, each giving a limited family service according to the objectives of the agency and the number of other agencies serving the community. For many reasons, relatively few agencies give a complete family nursing service including skilled care when illness occurs. In large communities there are many agencies with many nurses rendering many parcels of



nursing service, all of some value to the family. In 679 counties in the United States and in 31 rural and urban areas of 10,000 or more population there was in 1941 no community nursing of any kind, and all too many of these communities are remote from hospitals or medical centers. These areas, too, must be served if disaster strikes them.

Our progress to date has been summarized by Alma C. Haupt, executive secretary of the Subcommittee on Nursing:

... for the past one and a half years we have gone through the stages of: (1) setting up national machinery and doing country-wide planning (2) then developing state machinery—the state nursing councils—in which the state nurses' associations assumed leadership (3) local planning.

We are now in the stage in which local organization and local planning are of utmost importance. We need only to look at one community in which the calling out of a base hospital takes 35 of the teaching and supervisory staff from one of the leading teaching hospitals in the country to appreciate that we must know our local nursing resources; we must be analytical in reviewing every nursing job to evaluate its importance; we must be ready to share certain nursing functions with volunteer nurse's aides and nursing auxiliaries and at the same time maintain standards of service; we must be flexible in arranging for the necessary quick interchange of nurses from hospitals, private duty, or public health services locally as may be needed and then we must be ready to transfer groups of nurses from one community to another if emergency demands.\*

It would therefore appear that the public health nursing agency has three broad jobs to do, simultaneously:

1. To make such adjustments within the agency as may be necessary to carry on fully the essential services it is obligated to perform as part of its acknowledged community responsibility.

2. To assist in the selection, training, and assignment of inactive nurses, volunteer nurse's aides, and other auxili-

aries to supplement the skilled nursing service of the community.

3. To take an active part in planning a community service whereby its nursing power will be mobilized, evaluated, assigned, and instructed to discharge the assignments.

A consideration of each of these three jobs will indicate their relationship. Each community must be made as self-sufficient as possible, for only at that point can outside help be justified.

#### INTRA-AGENCY ADJUSTMENTS

Much has already been said about intra-agency adjustments through job analysis and through scrutiny of policy, plan of work, distribution of personnel, consideration of equipment, and selection of cases. The factors relating to selection, training, and assignment of volunteers and other auxiliary helpers have been discussed through the public press as well as the professional magazines. Especially helpful are the brochure published by the National Organization for Public Health Nursing on "The Volunteer in Public Health Nursing," and articles in *PUBLIC HEALTH NURSING* magazine such as the analysis by Grace Ross, "We plan Ahead."\*\* Miss Ross' outline suggests a way of evaluating each service, listing in inverse order of importance all activities carried by nurses, graded according to their requirement of technical skills, with designation of those which can be eliminated or turned over to a nurse without public health preparation. Administrative changes and preparation of substitute service are a necessary part of such adjustments. Planning before pressure occurs will prepare the agency for staff losses or for the substitution of new duties in place of those carried on in normal times.

Such a blueprint prepared in advance by every agency will give a feeling of

\*Haupt, Alma C. "The Government's Subcommittee on Nursing." *The American Journal of Nursing*, March 1942, page 263.

\*\**PUBLIC HEALTH NURSING*, June 1941 page 334.

security to administrative officers and to staff. It is designed to avoid confusion and to maintain morale. Through this method extra time can be found—without irreparable harm to standards and service—to participate in the activities outlined for us by our national nursing leaders and the federal emergency agencies. It is an orderly plan capable of gradual application. It also points out the type of supplementary assistance that will be needed to implement the program, and indicates the preliminary drilling necessary for each assignment. Obviously such foresight in planning for adjustments in program and such advance preparation for supplementary help will prove the best safeguard to standards of service.

#### COUNCIL HAS PREPARED GUIDE

Especially useful in preparation for such a comprehensive over-all plan for agency adjustment is Section 3-B of the guide, "Distribution of Nursing Service During War," prepared by the National Nursing Council for War Service. The N.O.P.H.N. contributed to this guide by summarizing the suggestions contained in recent studies and articles, and thus presented the facts to us in condensed form. A series of challenging questions is addressed to "those who have responsibility for planning, supporting, and administering community public health nursing services." The answers to these questions take us out of our respective agency boundaries, into full impact with the crux of our major problem—the utilization of nursing most efficiently and economically to meet the greatest needs of the people.

Consider the implications of these questions from the guide:

1. Is there duplication of service, resulting in unnecessarily high expenditure, because of the fact that numerous agencies in the community are administering public health nursing services of some kind to some extent?

2. Is every field nurse in the community

giving a general service, or are several public health nurses serving the same family for a variety of special services?

3. What possibilities are there in the community for joint utilization of personnel and facilities of public health nursing agencies? [With a shortage of supervisors, educational directors, and other personnel, with car and gasoline rationing, and other limitations, there is much significance in that question.]

4. Is full use made of opportunities for public health nursing services in clinics, health centers, and offices, to supplement services given in the home, thus reducing travel? [One might think of other methods to conserve time and gas. Has the use of letters and the telephone for appropriate purposes been explored far enough? Has the nurse scheduled her office hours at times designed to encourage visits—on Saturday afternoon when farmers come to town, or in the evening when the expectant mother and father might come together to discuss the need for medical care or plans for hospitalization?]

5. Are group methods utilized wherever practicable for more general health education and for supplementing individual and family health supervision given through visits to the home?

6. Do certain services represented in the public health nursing program of the community require more time and attention than others in this period of emergency, and should selectiveness of cases and services be practiced accordingly?

7. Are public health nurses doing work that others might be doing?

8. Have effective working relationships been developed as fully as possible between agencies of the community?

Having studied these questions, what then?

#### PLAN FOR COMMUNITY ACTION

Since "time is short," let us face facts squarely. No one agency can live and plan unto itself if it would serve the public. Only by a community plan, based upon the health problems and facilities of each community, with agreement among agencies to accept their respective roles in the total plan, can the community be properly served. There has been much talk about the inherent evils of the multiplicity of agencies and the necessity for amalgamation, thus arousing to arms all the protective spirit

of loyal members of boards and staffs. The important consideration is the *effect upon the community* of multiple agencies through duplication of effort and waste due to the diversion of money and personnel from more urgent services. With more demands for service than ever before, many of us believe that now is the time for careful analysis of all agency effort. Could not the point of attack be the coördination of the work of multiple agencies to the end that *community-wide* public health nursing becomes a reality?

In every community there must be a leader or leading group who can see the problem and who will initiate the first step to bring about improvement. In "Distribution of Nursing Service During War," mentioned above, the National Nursing Council for War Service suggests the establishment of a local nursing council with specified nurse, lay, and medical representation. This council is to be strong and dynamic. It will study nursing needs and resources. It will plan for distribution of nurses and the conduct of joint projects of concern to all. It will through concerted action more effectively assist recruitment and enrollment. It will enlist the services of inactive nurses; provide advisory service to nurses; inform the public about its community nursing services; secure community coöperation. It will utilize the National Survey of Registered Nurses as a useful tool in planning for all nursing services. The recommendations are clear-cut and pertinent. They indicate quite clearly a procedure for public health nursing agencies to follow in order to prepare for adjustments within their own field and be ready to contribute to community nursing in general.

An agency to be engaged in a sound public health program must relate its program to those problems which represent the greatest health hazards. It is only by defining these on a community basis that proper direction can be given

to the work. A community public health nursing committee might be formed, possibly as a committee of the community nursing council, if one has been established. The committee should be composed of the nurse directors and the directing officers of every agency rendering community nursing service.

Wherever possible, the health officer would be chosen as the natural leader of such a group—and he should be the leader in determining the health program for the community. If no such leadership is present, a way must be found without it until such time as it is available. To bring it about may be one essential in a long-range program.

In any event the outlining of a community health program cannot be done by nursing agencies alone.

Methods are suggested in the book on *Community Health Organization* by Dr. Ira V. Hiscock, and in the Appraisal Form for Local Health Work prepared by the American Public Health Association. Obviously until a program has been formulated on the basis of vital statistics and other health problems of the community there will be no way to judge the areas of greatest needs. Nor will it be possible to plan for the utilization in the most wise and effective manner of existing or diminishing nursing services. The plan must of necessity change with changing health conditions and in relation to war-time demands.

A large community master sheet divided into seven columns, such as the one suggested on page 377, is a useful device for analysis and planning. Three services have been used as illustrations here. Similar analyses can be made for all the nursing services needed in the community.

The services should be listed in descending order of their importance in relation to the health and welfare of the people. Only thus can selection be made of the most essential work to be done if available nursing service is insufficient to

# NURSING ACTIVITIES IN A COUNTY OR CITY OF 100,000 POPULATION

Type of service	Anticipated problem <sup>1</sup>	Anticipated service per unit of the problem <sup>2</sup>	Service	Hours of nursing service	Equivalent number of public health nurses	Supplementary service including lay and professional volunteers	Hours supplementary service <sup>4</sup>
Tuberculosis	250 active diagnosed cases registered with nursing service	12 visits per case registered with nursing service	Visits to and in behalf of patients or families; records; planning work; case conference; time with supervisor; other related work	3,000		Calling for sputum specimen; assisting with clerical work	200
	100 clinic sessions per year	5 hours of nurses' time for clinic session	Preparing for clinic; assisting at the clinic; work following clinic; cleaning up; report, et cetera	500	2	Chaperoning patients at clinics; taking temperatures; assisting x-ray technician; clerical work; assisting in preparation of patient for examination, et cetera	200
School health	20,000 school children in 25 schools	150 field visits per 1000 school children	Visits to and in behalf of school children; records; incidental work	3,000	12		
		Average of 3 hours in each school, each school day (270 school days)	Conferences with teachers, parents, children; assisting physicians with physical examinations; inspecting children; related work	20,250		Assisting with clerical work; assisting in immunization clinics; assisting during physical examinations, et cetera	2,500
Postpartum	525 patients receiving home nursing care	3 visits per case	Nursing care and instruction in home care; securing postpartum examination at the end of 6 weeks	1,575	1	Assisting with clerical work; make cord dressings; assisting in home with care of infant, combining patient's hair, changing bed, and assisting in other ways which will reduce time of visit for nurse	500

<sup>1</sup> Estimates of anticipated problem are based on Ira V. Hiscock's *Community Health Organization* (The Commonwealth Fund, New York, third edition, 1939)—section on "Personnel and Budget" for a city of 100,000, Chapter XI on public health nursing, pages 178-181.

<sup>2</sup> Standards for nursing visits per case and service are based on Appraisal Form for Local Health Work, prepared by the American Public Health Association.

<sup>3</sup> An average of one hour per visit is inclusive of every service incidental to a nursing visit including morbidity care when needed. Hiscock states that exclusive of overtime, each nurse can spend approximately 1900 hours on duty a year (*Community Health Organization*, page 178).

<sup>4</sup> Hours of supplementary service from other than staff public health nurses will reduce the hours of public health nursing service estimated in "Hours of Nursing Service" and may reduce the number of nurses.

NOTE: It is understood that each community presents a problem peculiar to itself. The three services listed above are merely given as examples to illustrate a method of making a work sheet to present nursing needs in the community.

meet all needs. It can also be decided what can be held in abeyance if emergency help is needed in other places. Each agency should prepare a similar blueprint of the service it renders. An estimate of cost is very important, since budgets must be balanced and adjustments made with income in mind. With the master plan for the community and each agency's plan on the table, a study of the whole in the light of the present emergency may point the way to certain adjustments.

#### WARTIME ADJUSTMENTS

Obviously the first step will be to decide what preventive services need immediate intensification, such as immunization against diphtheria and smallpox. Equally important will be the anticipation of nursing service which may be needed in the event of emergencies—such as casualties of active warfare, problems relating to evacuation, accidents in war industries, or epidemics. The department of health, department of education, a non-official nursing service, the American Red Cross, and the emergency medical service may each have major claims to various projects according to the nature of the problem and the agency's field of major competence or responsibility. Every need should be defined in relation to urgency, and by agreement allocated to one agency which should then assume administrative responsibility. A plan of procedure, necessary personnel, instruction of exchange staff if need be, supervision, and required reports are all part of such responsibility.

If such a division of the total task is arrived at through joint agreement, and the plans for each project discussed in conference, the coöperation of each agency is assured. It may be necessary to emphasize the master sheet suggested for the community, and each agency's blueprint of service should be a tool, the need for which grows out of joint plan-

ning. The initiator of a local community nursing council would do well to call such a conference on the basis of a clear-cut need of interest to all. It should be reasonably limited in scope, and capable of coöperative activities which do not shake the foundations of established practices or agency policies. A nursing service connected with the war effort has evident advantages. Unexpected avenues may be opened to bring about previously unthought of reforms, as techniques of coöperative thinking are learned.

In some places the way may be opened sooner or later for a unified community nursing service, with a pooling of staff and resources in order to utilize them to the best interest of the health program. In many places personnel is sufficient so that amalgamation would provide one nurse for 2000 or 3000 people and would allow for a generalized family service including nursing care of the sick in the home. Unified direction and supervision would be more economical, would spread available service and superior skills, and would admit of quick action if emergencies occur. Even if the ultimate goal cannot be reached, any step toward it will represent gain. If the channel is kept open to allow continued counseling together, that alone will bring further improvement as relationships grow stronger. Written agreements will strengthen these relationships. Written, they become part of agency policy and tend to be carried over through changes in directorship. Written agreements provide against loss of momentum in a continuing plan over a period of time.

Information about experiments in community planning to date may be secured from the N.O.P.H.N. The town of Eastchester in Westchester County, New York, is doing very well in providing a complete family service under a combined private agency and county health department service. Savannah,



Georgia, Berkeley, California, and Columbus, Ohio, are examples of complete or partial community planning. Other communities are now making plans to be put into action if emergencies occur.

So a start must be made. If only all the splendid experience and accomplishments of individual agencies could be pooled for the sake of the community they all serve, who can doubt the good that would come. Someone has said, "citizens, who have learned the art of thinking and of critical analysis, create an effective antitoxin toward short cuts,

ulterior Utopias, and shoddy procedures." Our job now is to apply our thinking and our critical analysis to our communities. If this is done wisely and with sufficient objectivity, we cannot doubt that enough nurses will be provided for our Army and Navy, and that through combined effort our whole body of nurses will be available for service to all the people.

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Presented before the N.O.P.H.N. general session on "Adjusting to Wartime Needs," Biennial Convention, Chicago, Illinois, May 19, 1942.

## NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

### PLACEMENTS

- \*Theda L. Waterman, director, Woonsocket Public Health Nursing Association, Woonsocket, R.I.
- \*Lydia C. Arndt, director, Public Health Nursing Association, Lincoln, Nebr.
- \*Catherine M. McDermott, nursing field consultant, American Red Cross Nursing Service, Midwestern Area, St. Louis, Mo.
- \*Martha Ida Hauk, maternal and child health advisory nurse, State Department of Public Health, Boise, Idaho.
- M. Elizabeth Hazard, instructor in summer session classes, The University of California, Los Angeles, Calif.
- \*Mrs. Edith Stiles Kivett, supervisor, American Red Cross, Ridgewood, N.J.
- Ruby M. Brouillette, county nurse, State Department of Health, Santa Fe, N.Mex.
- Ruth A. Ecklind, school nurse, Whitley County Schools, Columbia City, Ind.

- Mrs. Helen Shepherd Vinson, school nurse, Lemoore Union High School District, Lemoore, Calif.
- Mrs. Joyce VanVoorhis Brown, industrial nurse, Perfection Gear Company, Harvey, Ill.
- Mrs. Alice Marek Brown, industrial nurse, Hurley Machine Company, Chicago, Ill.
- Mrs. Irene Trumble Miller, field nurse, Visiting Nurse Association, Milwaukee, Wis.
- Susan Helen Connelly, camp nurse, Chicago Commons Farm Camp, New Buffalo, Mich.
- Dorothy M. Hoge, camp nurse, Burr Oaks Camp, Mukwonago, Wis.
- Mrs. Esther Osborne Wesner, camp nurse, Burr Oaks Camp, Mukwonago, Wis.

### ASSISTED PLACEMENTS

- \*Winifred L. Erskine, nursing consultant, American Red Cross Nursing Service, Eastern Area, Alexandria, Va.
- \*Anna Hassels, supervisor of nurses, City Health Department, Green Bay, Wis.
- Mrs. Leona Radman Antholz, county public health nurse, State Department of Health, Denver, Colo.
- Dorothy C. Grant, staff field nurse, Infant Welfare Society, Chicago, Ill.

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\*The N.O.P.H.N. files show that this nurse is a 1942 member.

# Teamwork to Protect the Worker

By KATHERINE GREEN BURRI, R.N.

**Specific ways are suggested by which the nurses in industry, clinic, and home, working closely together, can contribute to more effective tuberculosis control**

**T**HE NURSE in industry and the nurse in the general public health agency can work together effectively in many ways to control the spread of tuberculosis. Tuberculosis is not an industrial disease, except as it is a concomitant of certain dusty trades. The incidence of tuberculosis rises and falls with the standard of living among industrial workers as it does among other population groups. Almost every adult person today is a worker, and irrespective of his particular occupation, is subject to experiences and exposures that may later lead to his developing tuberculosis. In his home, at work, or in transportation, practically every worker in urban areas experiences overcrowding. He commonly suffers from physical and mental strains. His diet is probably deficient in several essentials. There may be tuberculosis among his co-workers. Time spent away from his work may bring him in contact with possible tuberculosis among his relatives, friends, or neighbors.

Obviously then, if the industrial nurse and general public health nurse are effectively to help the worker protect himself and his family from tuberculosis, they must consider the individual's total environment, and the hazards that exist in it for him. Their effectiveness as a team will to a large measure depend on how well they can integrate their respective responsibilities.

Someone once said, "People do not die from tuberculosis in this day and

age; they die from neglect." They fail to use available facilities for early diagnosis or to apply modern methods for treatment at once upon discovery of the disease. The extent to which an individual will use available resources depends largely upon his knowledge of tuberculosis and his attitude toward the disease.

The attitudes of three groups influence the success or failure of the program for control of tuberculosis in industry. The employer's chief interest is to keep his employees safe and well. The worker's first interest is his own security and well-being. The community is interested in keeping all people healthy and free from disease since no one is safe until all are safe. Although the ultimate achievement of the goal of each depends upon the others, these interests do not readily blend. The employer, to protect his interest, will adopt a policy of not hiring or retaining in employment tuberculous employees. The employee, unless assured of keeping his job, will hesitate to report to the medical service until long after he feels the need to do so. The community, to protect itself, will enact legislation that controls the physical environment and health habits of infectious tuberculous people, and restricts their employment in certain occupations.

In the nurse's relationship to these three groups, she is in the position of middleman. She has the unique opportunity of helping each one with whom

she comes in contact view the problem through the eyes of the others. When she can educate all to an awareness of the menace which tuberculosis holds for human life, she will help them to understand that eradication of the disease rests upon willingness of the individual to accept and carry out his responsibilities in the program for control, and upon the willingness of others to help him do it.

Early detection is the basis of all tuberculosis control. Therefore, present-day case-finding programs aim to discover unsuspected cases among apparently healthy individuals in groups where tuberculosis is relatively prevalent. One approach to finding cases among industrial groups is through the labor union.

#### LABOR UNIONS PARTICIPATE

Since 1939, the City of New York Department of Health, through the co-operation of organized labor, has conducted several mass x-ray surveys among apparently healthy industrial groups.\* The purpose of these surveys is to indicate the need, and to interest labor unions in assuming part of the task of eradicating tuberculosis. The union is responsible for securing the coöperation of its members. Lectures, motion pictures, exhibit material, and literature are made available to the union for that purpose. It is clearly understood that all findings will be a matter of confidence between the Department and the individual. Whenever possible, schedules are arranged to permit the employee to be x-rayed without loss of time from work.

One of the first surveys was made in the needle-trade worker group. Most of the unions included in the group are affiliated with the International Ladies' Garment Workers' Union. Approxi-

mately 26 percent of all the workers in the needle trades coöperated. In the dressmakers' union only 13 percent accepted examination, but among knit-goods workers 67.9 percent were examined. One hundred percent coöperation was not expected for various reasons, chief of which is the worker's fear that he may lose his job. Here again the need for understanding the importance of early detection is shown. Farsighted nurses will use the data collected on tuberculosis to show both management and the worker how early diagnosis is to the advantage of all—particularly the worker and his employer.

A total of 26,049 workers were examined—18,911 women and 7138 men. Of the men, approximately 27 percent were concentrated in the dressmaker and knit-goods trades. The race was predominantly white, only 4.8 percent being Negro. The average age was 33.9 years. The total number found to have clinically significant tuberculosis averaged 0.6 percent. Members of the children's-wear and the embroiderers' unions showed the lowest incidence of clinically significant lesions, 0.41 and 0.39 percent, respectively. The highest rate, 0.73 percent, occurred in the knit-goods unions. There was a marked increase of rate with advancing age, and more cases were found among men than among women.

As a result of one patient found with a lesion probably antedating his entrance to the union, the officials in several unions are planning to include an x-ray as a part of the union entrance examination. These unions have been convinced that the cost of this procedure will be less than rehabilitation of those admitted with the disease. Certainly it is to the advantage of the worker to know that he has the disease before engaging in strenuous physical labor.

I have selected for description this needle-trade survey from all those that have been made because it is the one

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\*This program has been carried out under the leadership of Dr. Herbert R. Edwards, director of the Bureau of Tuberculosis.

with which I am most familiar. The center of the garment-work industry is located in the lower west side of Manhattan. Although it is a practice to refer patients found in the survey to their family physician, or to the clinic in the district of their residence, many prefer to attend a clinic near their work location. Consequently many of these patients attend our lower west side clinic.

#### EDUCATION OF THE PATIENT

Our experience has shown that almost every patient found in the survey comes to the clinic with little or no knowledge of his disease. Even though the physician has informed him of his diagnosis, the clinic nurses find it very difficult to convince the asymptomatic patient that he has tuberculosis and needs medical care. Since the Department of Health has agreed to keep the findings confidential, the district nurse must assume most of the responsibility for patients found in the survey.

The asymptomatic tuberculosis patient will require the nurse's assistance in explaining to the family his need for rest and for their coöperation in establishing and following a regimen which will lead to his recovery. Also, certain procedures must be followed at home to prevent the spread of the disease. Both the patient and his family will need to learn how to enrich the family dietary simply and economically. In order that the entire family may understand the importance of prompt reporting to the physician if the patient should develop symptoms, the nurse will teach each member of the family the symptoms of the disease. If the physician has recommended hospital care, the nurse may have to help the patient and his family weigh family inconveniences against the advantages derived from such care. Or she may have to help make the arrangements for the patient's admission to the hospital. Because the physician will rely considerably upon the nurse's find-

ings in making his recommendations for the patient, it will be the health department nurse's responsibility to keep the doctor informed concerning the patient's adjustment to his new burden.

As a rule, the asymptomatic sputum-negative patient who is permitted to work can not be expected to carry out precautionary measures beyond the practice of habits of personal cleanliness. However, before he can conscientiously practice these habits the nurse will have to explain why he must cover his nose and mouth when coughing, sneezing, or spitting, refrain from kissing, and avoid using someone else's eating or drinking utensils. In addition, she will demonstrate the exact method he should use to cover his mouth and nose, and dispose of his sputum. Since his sputum must be observed constantly for tubercle bacilli, the nurse will encourage the patient to bring in a specimen for analysis at regular intervals, and show him how to collect it.

Our experience has shown also that even the person with a negative x-ray finding must be given an understanding of the disease. Otherwise he may believe he is immune to tuberculosis.

Because tuberculosis often develops very rapidly, pre-employment, periodic, or survey examinations will not discover all the cases of tuberculosis that will develop among industrial workers. There will be a certain number that are detected through symptoms. Every nurse, whether she is in the clinic, the home, or industry, should have an awareness of tuberculosis symptoms, and should recognize that any unexplained loss of weight, loss of appetite, hoarseness, cough, spitting of blood, hemorrhage, or pain in chest, must be considered as indicative of tuberculosis until proved otherwise.

A person's interest in an examination and his response to advice will in large measure be determined by the way in which he has been prepared. His pre-

vious experience with tuberculosis, his information about the disease, and his attitude are factors which the nurse must consider when she refers him for examination.

For instance, there is the person who, despite obvious symptoms, persistently refuses to consider tuberculosis as a possibility or to seek medical care. He requires assistance in understanding why it is to his advantage to know early whether or not he has tuberculosis. He may need assurance that if tuberculosis is found he will not be called upon to face his problem alone. The nurse who advises an individual to be examined must be ready to show him that she is truly interested in him as a person.

To conceal from an employee the reason why an examination is requested is unnecessary and unjust. Yet, employees frequently appear at a diagnostic clinic without any knowledge as to why they were asked to report. When questioned, the employee can only reply that he has been absent from work, or that the nurse told him to come. The outcome of this experience, particularly when tuberculosis is discovered, is fear, distrust, delinquency, and uncoöperativeness, all of which must be broken down before the employee can be helped. Adequate preparatory explanation, which includes a definite clinic appointment, and the name of the person to whom he is to report, helps both the employee and the clinic staff immeasurably.

#### CONSULTATION SERVICE OFFERED

The City of New York Department of Health, as a part of its regular tuberculosis clinic program, provides medical consultation to industrial medical departments that do not have diagnostic facilities. When efficiently managed, this type of arrangement offers unlimited opportunities for the industrial and community health services to make their combined efforts on behalf of the employee more beneficial. Employees are

referred by appointment. A brief summary of the employee's health history and the particular reason for referral are given at the time the appointment is made. When the employee is expected, the clinic can welcome him and show an interest in him personally. Immediately after the diagnosis is completed, a report of the doctor's findings and recommendations is sent to the referring medical service. Thus, both the clinic and the plant medical and nursing service can work together with knowledge of the problem and can advise one another freely about the patient's adjustment.

The district nurse is able to inform the industrial nurse regarding the sick employee's home responsibilities, his requirements in relation to his job, the amount and kind of rest he needs, and the guidance needed in regard to diet, exercise, and recreation. The industrial nurse can observe the employee at work, and advise the clinic and the district nurse about his alertness, his mental attitude, his capacity for work, and the effects of activity upon his general health. Moreover, she can arrange for him to be excused to keep his appointment with the doctor or the clinic. She can help him to plan his work so that he will not engage in activity beyond that normally required in his job. She can help him to keep his morale on a level conducive to health and recovery. If these adjustments can reasonably be made on his job, assuming of course that the physician deems it safe for him to work, the tuberculous employee can be helped towards recovery and rehabilitation.

#### REHABILITATION IN INDUSTRY

Although it is generally accepted that rehabilitation of the tuberculosis patient should begin as soon as the disease is discovered, the program for rehabilitation has barely been started. Resources are extremely limited. Nonetheless, nurses must recognize their



responsibilities in the rehabilitation of the patient and help him use the resources available. Undoubtedly as a result of the Nation's present tremendous industrial effort, many patients who are arrested cases of tuberculosis will return to active full-time employment. While the industrial nurse will be primarily concerned with helping such an employee to remain healthy and free from active disease, she should help him to appreciate his responsibilities toward himself, his family and the community. Also she may have to point out to his employer that with continuous medical supervision and the mental and economic security resulting from his being employed, the man who is an arrested case has more than a good chance of retaining his health.

Because tuberculosis is a communicable disease it has become the practice to examine all tuberculosis contacts. Examinations of persons who have been in prolonged and intimate association with positive-sputum patients consistently yield the greatest percentage of cases of unsuspected tuberculosis. Usually the first examination of contacts is secured easily. The more difficult job is to keep the individual's interest sustained during the period he must continue under supervision. The industrial nurse can help the contact understand that tuberculosis is a communicable disease, which

usually has a long and varied incubation period and commonly develops without symptoms. Moreover, she can help him see the relationship between good nutrition and good personal hygiene, and his health and well-being. The district nurse can help the contact by arranging his clinic appointments conveniently for him, and by advising the physician concerning his problems. The district nurse and the industrial nurse must share the responsibility for giving the contact the information and guidance he needs if his interest and cooperation are to be sustained.

Today, more than ever before, the protection of the worker and his home from tuberculosis is one of the most serious public health problems with which nurses are confronted. To do an effective job, public health nurses working in industry, clinic, and home must constantly be ready to enlarge their knowledge of the disease and improve their methods of teaching. They must know where to look for the disease, the symptoms by which it manifests itself, and what to do when its presence is suspected. Teamwork on the part of all is the key to the eradication of tuberculosis.

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## THE AMERICAN JOURNAL OF NURSING FOR JULY

The American Cause.....	Walter Lippmann
Shock .....	Stanley S. Atkins, M.D.
Tetanus.....	Ralph Spaeth, M.D.
The Nursing Care of Tetanus.....	Marguerite L. Martin, R.N. and Ruby Corzine, R.N.
Our Staff Nurse Program Continues.....	Ruth Chamberlin, R.N.
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Maintaining the Quality of Nursing Service in the Emergency.....	Clare Dennison, R.N.
ARC Volunteer Nurse's Aides.....	Elizabeth H. Rath, R.N.
Our ARC Volunteer Nurse's Aides.....	Mabel A. Barron, R.N.
The Curriculum in the Emergency.....	Ruth Sleeper, R.N.

# The Fund-Raising Problem

By CLARENCE J. MYERS

**T**HE DAYS when institutions and organizations, regardless of the quality or timeliness of their work, could ask for funds and get them—or in many cases get support without even asking—have passed. All privately supported agencies face new problems. The difficulties of the present as they relate to fund-raising are known to all of us. In the main they are brought about by war—total war. Mounting taxes, dislocation in all phases of life, added home and business responsibilities, new personal anxieties—these affect both giving and working. Gifts and service to individual agencies are also affected by the great war appeals—American Red Cross, United Service Organizations, United China Relief. There is also the sincere and growing feeling on the part of some people that the government should finance many of our private agencies. Obviously these developments do not present a favorable setting for raising money.

At the same time many private agencies are asked to render an even larger measure of service than before, especially in industrial communities. To add to the difficulties, income from invested funds is declining. Old contributors are passing away. Often members of the younger generation are not interested in the philanthropies of their fathers. Many generous citizens find it necessary to reduce or completely eliminate former benefactions.

Many aspects of this present-day picture are due to factors beyond our control, and our plans must be made accordingly. The board of each organization must decide which of four courses of action it will pursue. The first is the

easy way out: give up the ghost and pass out of the picture. The second is to let the city, county, or state take over the work. The third is to draw on unrestricted capital funds, if any exist. A few agencies might proceed on this basis for a time, but the great majority not for long. I need not mention the unsoundness of this third move from the standpoint of sound management and long-range stability, or the loss of public interest in the work due to the absence of all activities incident to seeking general support. The fourth is to make a vigorous effort to survive by securing the maximum amount available in tax funds for your individual agency, and by also enlisting adequate voluntary support.

## SELF-ANALYSIS IS FIRST STEP

The first step in present-day fund raising is one of objective self-analysis. May I suggest that you ask yourselves the following questions, among others, and get realistic answers to them? Your potential supporters will ask them:

1. Is any phase of our work duplicated by another local agency? If so, is there some way of combining that service, thereby doing a better job on less money?

2. Do the community and experts in our field think we are doing the very best job we can do today within the limits of our resources? (Just because you have an established reputation and have rendered effective service in the past is not a convincing answer in 1942.)

3. Do business men in our city, in addition to doctors and public health officials, believe our job is done eco-

nomically? Today agency budgets must be scrutinized with the greatest care.

Still another field of self-analysis will pay dividends—namely, what is right or wrong with your year-round public relations program. Ask yourselves these questions:

1. Have we troubled to consider the state of mind of the constituency upon whose good will we are dependent?

2. Are we willing to set our house in order if intelligent criticism reveals the necessity?

3. Have we assumed that because we were doing a fine job everybody knew about our good works? Or have we kept our present and potential friends closely informed as to what we were doing and how we were doing it? Or have we waited to inform our donors as to the importance, timeliness, and quality of our services until we were about to launch an appeal for support?

The answers to these questions will largely determine whether you are ready for fund-raising, and how successful you will be. The agency which neglects its natural constituency and does not *continuously* cultivate its understanding and good will will be passed by in time of need. The givers to our private agencies are the equivalent of voters in our political life. They hold the power to determine whether these institutions shall live or die. If the facts are adequately set before them, they can be depended on for a fair verdict.

#### WIN FRIENDS FOR YOUR AGENCY

Therefore, it might be helpful at this point to review some of the things which might be done by public health nursing agencies to win support from friends and influence the general public in their respective communities:

1. Cultivate your board members. This may sound strange, but during the past 20 years I have been surprised on many occasions to find how little public-spirited citizens knew of the actual

workings of agencies on whose boards they served. Sometimes this was their own neglect. More often it was the agencies' fault because all that was asked was attendance at quarterly or annual meetings. You must constantly bear in mind that board members are of value not only because of their advice and counsel but also they are potential donors and workers in securing support. The greater their knowledge of your agency, the greater their enthusiasm and hence their ability to enthruse others in the community.

2. Send a brief, attractive annual report to all past, present, and potential contributors. It need not be very detailed, but it should definitely create the impression that the public is being taken into your confidence.

3. Send out a quarterly news letter, possibly a four-page printed bulletin, or a well mimeographed memorandum or letter from the president of your board. These should not ask for money; they should be purely informative.

4. See that committee members are rotated so that more people can take an active part in your work.

5. Invite people, whenever possible, to attend special meetings or demonstrations, or to see new exhibits or films.

6. Seek the advice of leaders in your community. Perhaps an advisory council can be organized and meet once a year at a dinner.

7. Invite local lawyers, trust officers, and executives in insurance companies to serve on a permanent bequests committee.

8. Establish favorable relations with the local newspapers so that they will give generously of space for copy and pictures. However, do not ask favors. Give them good material presented in the proper form.

9. Seek opportunity to present your story before local groups and clubs at least once a year.

Good will and understanding mean

support. Support means money. Over a period of years, lasting good will is not only the best assurance of adequate financial support; it is the only assurance thereof. Like everything worth having in life, it does not come of itself. It must be deserved, planned, and worked for. Under present circumstances the survival of organized private giving in America probably depends in a large measure on the cultivation of an intelligent public opinion. This will result only through individual agencies' adopting as a regular part of their life and work, public relations programs which are as ably planned and conducted as any other phase of their service.

Now as to fund-raising. In some cases, of course, private support reaches agencies through the channels of a local community welfare fund. However, nothing I say is inconsistent with that situation. Good will generated by your own cultivation will stand you in good stead. The more thorough the work done in connection with board members, past donors, and present and potential donors, the greater the response in time as well as money when they are asked to help.

I do, however, want to discuss particularly, certain phases of a campaign where an independent effort is conducted. These points are, in my judgment, important both for agencies in larger communities where organized fund-raising is concentrated in a limited time period, and for agencies in smaller communities where fund-raising is less formal.

#### APPEAL FOR ANNUAL SUPPORT

At present, building and endowment appeals are not feasible. Priority rulings, of course, forbid building new buildings even if you raise the money; and by and large, the present-day donor is not interested in giving to endowment funds. He naturally feels in these times

that institutions should not attempt to build up future reserves.

The one appeal which can be presented with hope for success is for annual support. In setting your financial goal, determine first what can be expected from tax funds. This amount subtracted from your annual budget will determine the goal to be presented to the giving public.

Then there are always the questions: "Should we present our bare needs, or can we ask support for some new phase of work, or should we allow some leeway for possible expansion of services?" No hard and fast answer can be given. However, any objective must be governed by the fact that we are involved in a grim war. Every dollar counts, and frills and extras and experiments will only weaken your appeal.

#### TIME YOUR APPEAL

If at all possible, an appeal for annual support should be limited to a particular time each year. Continuous requests wear out your welcome. Furthermore, it is to the advantage of each organization to get people in the habit of giving their time and money at about the same time each year. It avoids confusion in the minds of donors and tends to eliminate complications with the appeals of other agencies.

It is a fundamental principle that the amount of money raised is determined in part by the degree of thoroughness of every step. However, volunteers will not work on a fund-raising committee over an extended period. The demands on their time are too great. You are much more likely to secure their coöperation if, when the invitation is extended, you are in a position to limit responsibility and the period of time each is asked to serve. Under these circumstances, more time must be spent by the inner group in more thorough planning of each step in the fund-raising program.

Strong leadership and an effective volunteer-soliciting organization are always essential to success in raising money. It is not only what you are doing but who is helping you that makes the strongest appeal. This is truer today than ever before in view of the multiplicity of appeals. The appeal that receives major consideration is the one backed by and participated in by key people. Board members must take an active part. If they will not help, then you can hardly expect outsiders to do so.

#### WORKERS NEED LEADERSHIP

To enlist the type of leadership and cooperation you would like to have and must have if the maximum results are to be obtained, it is more than ever essential to keep these things in mind: (1) Headquarters must give specific suggestions and provide adequate tools for doing the job in the right way. (2) A greater division of responsibility must be effected so that no one person or group will be unduly burdened. (3) The number of meetings you can expect people to attend is definitely limited. (4) Meetings must be short—no one will give time to long-winded discussions on details or nonessential matters. (5) Workers must be better informed as to what they are selling. Resistance to giving is greater now and the arguments in favor of giving must be presented effectively.

#### MAKE OUT A GOOD CASE

Today public opinion demands that everything must contribute to the successful outcome of the war. Gear your appeal to that demand. It is not what we did a year ago, or six months ago, that counts, but what we are doing today to make our contribution to ultimate victory. Public health nursing in the war is essential, timely, and appealing. Your agencies are particularly fortunate in that. Your work is more than ever necessary. If adequately and effectively

presented, it will be so recognized by your community.

In presenting your case, dramatize it. Weave in your human interest stories. Show by example what you are doing and how you are doing it. Point out that the donor has a personal as well as a social interest in supporting your work. Certainly the maintenance of a high standard of public health is a matter of personal concern.

Furthermore, do not simply present your budget of needs in cold figures. Break it down into as many appealing items as possible. People like to feel close to their gifts in terms of what their individual gifts will do. For example, if I give so many dollars, how many visits can a nurse make because of my gift? Or what part of a nurse's salary can be paid because I have contributed X dollars? Breaking your budget down into possible unit gifts not only makes a stronger appeal but invariably raises the standard of giving and makes a donor a closer friend of the institution he is supporting.

#### WHO WILL GIVE?

Particularly now, the most careful analysis of potential supporters is essential. Old names of larger donors need to be reclassified as to their giving ability. Names of possible new contributors must be added. In general, it might be said that every adult in your community is a potential contributor to your work because of its broad community implications. However, on a realistic basis this is not true. There are no doubt whole sections whose residents are obviously not potential contributors. Even in more prosperous sections, selection of possible donors will save time and money.

Broaden your base of support, for many former donors may not be in a position to give as generously as they have in the past. Increased employment due to the war might well add, in many industrial communities, a new group of



modest but numerous potential donors. In the old days it was sufficient to have the confidence of a relatively small group of wealthy and socially prominent patrons. This is still important. But today private agencies simply cannot exist without the support of givers of small amounts.

Utilize to the fullest the knowledge of people in your community which your staff possesses. The very nature of their work often gives staff members an insight into the interests of the people they serve. Furthermore, your nurses' enthusiasm for the work they are doing transmits itself to others and hence is a tremendous asset in your public relations program.

#### LISTS SHOULD DISCRIMINATE

Just a list of names and addresses is of little value. The most valuable special gifts list contains on each name card up-to-date data on the person's interests, giving ability, previous benefactions, and connections. This information is invaluable if effective approaches are to be planned in each case. In general, names should be classified under three general groups: (1) the 10 to 25 people who are in a position to make very substantial contributions (2) those who can give larger than average gifts and to whom the appeal should be presented through personal solicitation (3) the group the great majority of whom can be reached only through mail appeals.

#### MAIL APPEALS HELP

I would not depend on mail appeals to raise substantial sums. They may be a helpful supplement to personal solicitation and a means of reaching a larger group than would be possible through personal contact. Furthermore, as a channel for cultivating broader interest they have their place. A series of two or three letters to a carefully selected list of reasonable proportions will raise

more money than one letter to a very large list. Do not stuff the envelop with all sorts of inserts.

Under the conditions outlined, we have found that the most effective mail appeal is one organized on a personal basis. A group of people are asked to write personal letters. Careful selection is made of the names each person agrees to write to. The letters are personal and written on the signer's own stationery. Because of their personal nature they receive attention and stand the best chance of enlisting a favorable response.

#### MAKE YOUR PUBLICITY COUNT

Publicity in and of itself will not raise money, but it is an essential tool. If well done, it arouses interest and paves the way for the direct appeal. The presentation of your case should be short and very much to the point. Pictures carry more weight than before. In your work there are many human interest stories. Use them. Graphs, charts, and tabular analyses are popular. The points you wish to emphasize can and should be made easy to grasp. People will not take the time to wade through a lot of solid copy, no matter how interestingly it may be written.

More attention needs to be given to format, layout, and use of type. The advice of a good layout man should be sought. Attractive printing does not cost more and it does increase immeasurably the effectiveness of your story. Quality still pays dividends.

In addition to the major case booklet, which tells the whole story between two covers, some organizations have used successfully a series of two or three short bulletins, each one taking up a particular phase of an organization's service. The bulletins, sent out at ten-day intervals during the course of a fund-raising effort, attract attention, are read because they are short and discuss a single subject, and build up interest over a period of time.

As a means of enlisting and informing workers, and developing interest and momentum, meetings still play a vital part in raising funds. However, under present circumstances they must not be too frequent and most certainly not too long. Some of the best attended report meetings are held in the late afternoon where tea or other refreshments are served. Men, in particular, seem to prefer a late afternoon meeting rather than a luncheon, dinner, or evening meeting.

#### **HOLD SHORT, SNAPPY MEETINGS**

In some fund-raising efforts, a series of such meetings in clubs or private homes has been carried on with great success. To these gatherings are invited both potential workers and givers. The work of the organization and its needs are outlined by prominent speakers. The coöperation of those present is sought both in giving and willingness to solicit others to give. Small meetings to which people are invited by a host or group of hosts have proved particularly effective.

#### **HAVE A CAMPAIGN BUDGET**

Business men recognize the basic principle that it costs money to get business. Public relations, advertising, and sales costs have become an accepted part of the essential and regular expenditures of every business. The same principle holds true in private giving. It costs money to get money.

Some agencies feel that because they spend very little to get money they are wisely conserving their resources, or are utilizing available funds more effectively in other directions. In such cases a disinterested appraisal would, no doubt, reveal that additional expenditures for cultivation would prove a very profitable investment.

You can not carry on an effective public relations and fund-raising program without adequate funds for secre-

tarial and clerical help, mimeographing, printing, pictures, postage, meetings, and other necessities. Such money does not just disappear into the void. Besides bringing immediate financial returns, these efforts often enlist strong members of boards and committees, enlarge interest, educate the community, enhance prestige, and obtain bequests. The many activities essential to a well planned and directed program all have value in themselves, independent of the amount raised.

The subjects just discussed are important, whether you are seeking \$5000 or \$50,000 or \$500,000, or conducting your fund-raising on a less formal basis. Attention to these points pays dividends.

#### **CAN WE ENDURE?**

In conclusion, may I say a word as to the future. Many thoughtful people are asking what is going to happen to our privately supported American agencies. The answer is not clear. The world is the scene of kaleidoscopic changes. They are far-reaching in their import and will affect the course of the lives of future generations. In the march of progress our voluntary philanthropies have acted through our country's history as pioneers, in education, nursing, hospitalization, poor relief, provision of playground facilities, and other services—the constant, quiet leaders in our Nation's progress toward a better life for all our people. A vast work lies ahead. To be sure, some agencies have been expressions of individual whims or prejudices and are today without social justification. Some are outmoded by changed conditions, or duplicate the work of others; some are in a rut; others have no clear-cut policy. Nevertheless, as a group they represent one of the foundation stones of American life.

More than at any time in our history, every institution must justify its existence under private control. The good

citizen must take a more active interest in the agencies and institutions serving his community. He must be willing to serve on boards and committees and to help in solving many pressing problems. He must give according to his means for the preservation of those things in which he believes.

If American institutions are worth maintaining, they are worth working for and sacrificing for under extremely adverse conditions.

Each agency must face squarely its individual situation. Ask yourselves these questions: Are we doing a work today that justifies public support? Do we need help now? Have we faith in our cause? If your answer is in the

affirmative, you are justified in presenting your appeal. The task will not be easy. It will require hard work, patience, and time. The concrete results will not be what they would be under normal conditions. On the other hand, it must not be forgotten that bequests are now being written into wills, that generous and sacrificial gifts are being made, that many thousands of men and women are giving and will continue to give of their time and energy as volunteers in the cause of American health and welfare.

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Presented before the N.O.P.H.N. Round Table on Fund-Raising, Biennial Convention, Chicago, Illinois, May 21, 1942. Published in condensed form.

## RECORDS ROOM AT THE BIENNIAL

THE N.O.P.H.N. Records Committee wishes to express its appreciation for the interest and response shown by public health nursing agencies in the careful selection of case records submitted for the record exhibit and for the valuable assistance given by board members and nurses in the Records Room at the Biennial.

Among the 156 records received from 86 agencies in 26 states, the District of Columbia and Canada, 15 different types of service were represented. In addition, various time study schedules, day sheets, and monthly reports were submitted. These records were indexed in three ways, according to:

1. Geography and agency (Alabama to Wisconsin)
2. Type of record (antepartum to venereal disease)
3. Points of interest (child guidance to visual aids)

Interest in the Records Room was demonstrated by the fact that 156 separate individuals from 27 states and Canada visited the exhibit. In all, the records were called for 792 times, 62 of them 5 times or more. Those most in demand were on the subjects of orthopedics, tuberculosis, child health, and industrial nursing. The 9 industrial records on hand were reviewed 119 times.

Most of the records from the exhibit are now available on a two-weeks' loan basis, free of charge except for postage or express charges, to members of the N.O.P.H.N. We sincerely hope that the record exhibit will continue to provide a means for exchanging ideas about record forms and record-writing.

MARIE L. JOHNSON, R.N., *Chairman*  
*N.O.P.H.N. Records Committee*

# Rationing Health Services in Wartime

By GEORGE ST. J. PERROTT

**More rather than less medical services are needed in wartime and our limited physician and nurse supply may be in for a period of priorities and rationing**

**C**IVILIAN HEALTH needs the safeguard of the rationing and priorities that go with modern war. We civilians must share our doctors, dentists, nurses, engineers, and technicians with the military forces. There will be enough of such services to go around only if there is wise sharing, so that the available civilian supply reaches the areas and people who need them most, and then only if new personnel are trained rapidly and well.

This country has a sizable army of people engaged in some phase of the health service—160,000 doctors, 70,000 dentists, 200,000 nurses. Counting other professional and technical personnel, practical nurses and nurses' aides, this army is over 1,000,000 strong.

If the military forces should reach 8,000,000, only 6 percent of our population will have been withdrawn. But this 6 percent would require 33 percent of the nation's doctors, 17 percent of its dentists, and 20 percent of its nurses if present ratios are maintained. This would mean the withdrawal from civilian practice of 52,000 doctors, 12,000 dentists, and 40,000 nurses. The Army and Navy will also need technicians, dietitians, bacteriologists, sanitary engineers, and others who together make up the million persons normally available for civilian health services.

Such withdrawals may not seem very serious when considered as averages. For example, the loss of 52,000 doctors to the military establishment would still leave one physician for every 1150 per-

sons in the country. Without overwork, one doctor could probably care for 1150 people. But the averages are only statistical abstractions and have no basis in reality. This would be a simple war if we could deal in averages.

## PREWAR SERVICE INADEQUATE

Examined in its practical details, the picture shows that only the younger, physically fit physicians can be used by the Army. Thus a very large proportion of all physicians under 45 years of age might be needed. Again, we find that there are whole states where the number of persons per actively practicing physician is over 1500, and counties where the ratio runs as high as one physician to 5000 persons. A number of counties have no physicians at all. Obviously in many states and localities, most of the existing physicians should be left to protect the health of the local community.

What is true of physicians is true of other medical personnel and facilities. Even in peacetime, full-time health services were lacking or inadequate in many areas, public health nurses were conspicuous by their absence or were forced to spread their efforts over too many people, hospital beds were inadequate to meet the needs.

The first part of a wise plan of sharing medical personnel between military and civilian needs will require that areas where services are already at a minimum be allowed to retain their existing supply of doctors, dentists, nurses, and others engaged in health work.

But shortages are being produced not only by withdrawals into the military forces but also by rapid migration of workers and other civilians into war production areas and extra-military zones. These population increases would have resulted in deficiencies in health and medical services even if no physicians and other health personnel had left the area. Demands have been placed on official health agencies whose resources were insufficient to meet the needs. Sanitation services that most of us take for granted, such as a supply of pure water and milk, and sewage and refuse disposal, have not been available. Medical and hospital facilities have been grossly inadequate. Let us look at conditions in three of these areas:

In an area in a large and relatively prosperous middle western state, in which an ordnance plant employing 10,000 workers is nearing completion, the shortage of public health personnel has made it impossible to replace, for the time being at least, one of the district health officers. The health officer in the adjoining district, already a large one, is carrying both districts. He and his staff of two sanitary engineers, two nurses, and two clerks are responsible for the public health care of 16 counties.

The county surrounding a large Army camp in an east south central state presents a somewhat different problem. Exclusive of the 50,000 military population of the camp, the county has increased from 29,000 to 50,000 persons in the past two years. Owing largely to uncertainty as to whether two villages now surrounded by the expanding camp are to be bought up by the Army, the residents refuse to make sanitary or other improvements on their property. Contrasting sharply with the excellent sanitation within the camp are the deplorable conditions in the immediate vicinity. In one of these villages, housing about 600 persons, 80 percent of whom are military personnel and their families, more

than half have unsafe water supply, one third use unpasteurized milk, and no less than seven eighths have unsafe sewage disposal facilities—mostly open privies. Some of these, in fact, actually drain into a stream which flows through the camp. That no serious outbreak of disease has occurred in this area as yet is fortunate. I say it is fortunate; it is doubly so because the nearest hospital, other than that on the Army post, is 34 miles away, and the 50,000 persons of the county are dependent on 13 physicians, 9 of whom are over 60 years of age.

A coastal county with a population of 27,000 in 1940 has increased in size to about 35,000 because of influx of workers to a new war production plant. A much needed county health department has recently been organized, and given offices in the rather crowded county courthouse. Indeed the crowding is such that the course of justice often impedes control of the public health, for the office is in the jury room, and when the jury deliberates, health must wait. Sanitary provisions are inadequate, doctors scarce, hospital beds too few. However, when construction of water and sewerage systems and additional hospital facilities have been completed with Community Facilities Act funds, conditions here will be greatly improved.

#### REHABILITATION OF UNFIT

There are other urgent needs which will tax our medical resources. One is the rehabilitation of the physically unfit. Selective Service has shown us that not all of our young men are perfect specimens. Some of the men rejected are not handicapped in their civilian activities, but others if given adequate medical rehabilitation could contribute more effectively to the war effort. Increasing numbers of industrial accidents are enlarging the rehabilitation problem. Victims of enemy action will add to the



total. The need for maintenance of morale, and ever-growing war production demands for more and more hours of work will force us to take measures to meet the problem.

Selective Service has announced that it may have to induct men with dependents, and proposals for cash allowances to take care of dependents of soldiers are being considered. However, no individual monthly cash allowance will take care of unpredictable medical expenses, and here again is a problem which must be solved.

The net result of all this is the need for more rather than less medical service per person in the civilian population. How can it be done with diminished personnel?

#### SHORTAGE IS ALREADY ACUTE

Statistical evidence of the magnitude of personnel shortages was obtained in a survey of health departments and hospitals made in January 1942 by the U. S. Public Health Service in coöperation with the Procurement and Assignment Service and the American Hospital Association.

Reports from state, city, and county health departments indicated a total shortage of some 6000 persons. Nearly one half of the personnel needed are public health nurses, about one tenth are physicians, and one quarter are sanitary engineers and other sanitation personnel. The effect upon the efficiency of a health department of the loss of one or two key persons cannot be adequately measured by the number of vacancies alone. Health departments operate with a relatively small staff of professionally and technically trained persons. The loss of a few such persons may bring many phases of the program to a virtual standstill.

The hospital survey indicated a need for some 20,000 nonmedical professional and technical persons to fill current vacancies in private and nonfederal gov-

ernmental hospitals, and an additional 20,000 persons for new facilities under construction or planned. Here again, persons giving nursing care are in greatest demand. Forty-five percent of the total number of persons needed are graduate nurses, 21 percent are student nurses, while 25 percent are orderlies, practical nurses, trained attendants, and other persons giving nursing care. The other 9 percent are fairly evenly distributed among the other types of technical persons.

Many hospitals report that the difficulty of obtaining internes, residents, and service and maintenance personnel is fully as great as the difficulty of obtaining technically trained persons. This shortage of personnel is partially the result of increased demand for hospital service arising from the higher income of wage workers, and in certain areas from a rapid expansion of population because of expansion of war industries. Equally important, however, is loss of personnel to the armed forces and competition from war industries where higher wages and shorter hours of employment can be obtained.

#### PROGRAM TO MEET NEEDS

What has been done to meet these problems? To maintain the balance between medical services for the civilian and for the military population, the Procurement and Assignment Service of the War Manpower Commission is working with recruiting officers of the Army and Navy and with Selective Service to allocate medical manpower equitably for the war effort. Such coordinated planning is obviously essential.

Through the Community Facilities Act, and through federal-state programs of the Public Health Service, the Children's Bureau, and other agencies, a beginning is being made in providing personnel and facilities in war areas. The Office of Civilian Defense and the Public Health Service have a joint plan

for emergency medical services for persons needing them because of enemy action. The nursing education program made possible by an appropriation of \$1,200,000 to the Public Health Service will add to the available supply of nurses. Increased enrollment and elimination of the summer vacation in medical schools will eventually increase our rate of production of physicians. But the gap between accomplishments and needs is still very great.

#### COORDINATED PLANNING NECESSARY

In summary, war is bringing increased civilian needs for health and medical services, and an overall decrease in the available doctors, dentists, nurses, and others who render such services. Just as in the case of commodities, we are in for a period of priorities and rationing if the available health personnel and facilities are to meet both military and civilian needs.

It is obvious that the Army and Navy must come first and that luxury medical care for civilians has no place in wartime. But the Army and Navy must leave us civilians sufficient personnel to provide the minimum necessary public health services. Civilian hospitals must continue to function. Medical schools must continue their work and at an increased pace. Medical care must be available to workers and their dependents in the war industries. There must be medical services for dependents of soldiers, for civilians needing care because of enemy action, and for essential rehabilitation services. Maternal and child health services must not suffer.

Can we achieve the apparently impossible task of providing increased civilian health services with a decreased number of professional personnel? It can be done but it will require coordinated planning to make the most effective use of doctors, dentists, nurses, and facilities. The planners might well take a leaf from the book of the nursing profession which has shown great vision in this emergency. The program of the National Nursing Council for War Service, through local nursing councils, involves study of local needs, recruitment of students, enlistment of the services of nurses who have been professionally inactive, encouragement of economy of nursing time through group nursing, avoidance of "luxury" nursing, and allocation of nonprofessional workers to non-nursing duties.

This type of local study and economy of professional time through group action is needed in every phase of our health and medical services, if civilian health needs are to be met. It will require a degree of coordinated effort between all agencies, public and private, federal, state, and local, such as this country has never seen, and such as can exist only if personal interests and long standing professional prejudices are sacrificed for the common cause. There is every reason to believe that the effort will be made, and that it will be successful, not only in solving the immediate problem but in setting an improved pattern for the nation's postwar health services.

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Presented before the N.O.P.H.N. General Session, Biennial Convention, Chicago, Illinois, May 22, 1942.

The revisions in the N.O.P.H.N. bylaws were accepted as sent to the membership.

# The Nurse as Health Counselor in Camp

By ALFHILD J. AXELSON, R.N.

**P**UBLIC HEALTH has always emphasized the importance of taking the offensive in health, of preventing disease. War has given an added impetus in this direction. It was never so vital as now that the whole nation have an abundance of health.

Camps give us an unusual opportunity to take the offensive in the health care of children, for camps are set up for healthful living. They offer vigorous outdoor activity; rhythmic routines of eating, rest, sleep, play, and work; and an opportunity to acquire various skills in swimming, tennis, and other activities, which give the child a sense of well-being, because for one thing they give him status in his group.

Opportunities for this kind of wholesome living for children seem to be on the increase. Many organizations for child care have camps for children, and many private schools own camps or farms. With public schools assuming an increasing responsibility for the welfare of children, particularly in time of war, one wonders whether camps may not become extensions of the schools. At least a few educators are advocating this.

The nurse should play a constructive part in camp life. From my own experience as camp nurse it seems to me she can best do this by being a health counselor. With the other counselors she is then a part of the camp organization instead of an isolated worker. It is taken for granted that she attend all counselors' meetings. She helps to plan activities. She may advise a modification of the program if that is necessary for the health of the children. In

meetings for the purpose of discussing the children she contributes information about the health of individual children. Being a health counselor emphasizes the preventive, the health aspects of her work as a nurse and also perhaps has the advantage of immediately placing her as a camper.

## PREPARING CHILD FOR CAMP

The nurse health counselor must be intelligent about the three phases of camp health work for children—preparation of the child for camp, health life in camp, and health reporting when camp is over.

Most camps require that children have a thorough physical examination by a physician in preparation for camp. They emphasize particularly a careful examination of the heart and a urinalysis. The findings of this examination, with definite recommendations by the doctor, are usually sent to the camp director on physical examination blanks which the camp supplies. A successful vaccination against smallpox and immunization against diphtheria are also generally required. Usually great emphasis is placed upon the correction of a child's remedial defects, found by the examination, before he comes to camp.

The camp should also have health histories of children, including health histories of their families. The camp must know if a child is allergic, if he has any physical or emotional handicap. The family health histories were of very great benefit in a camp in which I was health counselor. The fact, for example, that an enormously overweight girl in her teens wanted carbohydrates

particularly was of added health significance to us because her mother was diabetic.

If a child has been exposed to a communicable disease before camp opens, parents should inform the director who usually has a definite policy regarding such exposure. Most camps exclude these children until the end of the incubation period of the disease to which they are exposed.

#### HEALTHFUL LIVING IN CAMP

Sanitation and hygiene are important for healthful living. In many states the state department of health sets up minimum standards for camps. It inspects camps to see that they meet standards of good ground drainage, pure water and adequately high bubbling drinking fountains, sanitary toilets, proper disposal of garbage, screened kitchens and dining rooms, and spacing of sleeping cots at least six feet apart. To live up to the latter requirement one camp had to increase the space between cots—the director had overcrowded her camp—by having every other girl sleep with her head at the foot of the bed.

Camp sanitation with its many ramifications is extremely important for camp health and is a subject about which the nurse in camp should know a good deal. That sunshine reach the beds upon which campers sleep has always seemed important to me. Sometimes one finds cabins in such deep shade that the sun never reaches them. Then, too, it seems desirable that the children live in small units of four to six in a cabin with a counselor rather than having all under one or two roofs. The small unit gives more adequate protection from disease. It also eliminates the emotional impact of many personalities upon a child, which can be very fatiguing.

To play a significant role in camp hygiene or in the personal healthful

living of children, the nurse needs to know what a healthy child is like. She should have a clear picture in her mind. Surely we agree that this is an eager, outgoing, happy, active child, or at least a well integrated, emotionally balanced child. We do not want a neurotic child, but we do want him to be intelligent about health.

For one thing the children should know what makes for a healthful environment for a group. It is always well for the nurse to explain to them during one of the general campers' meetings, the physical setup of the camp and the way it meets sanitation regulations. For example, they should understand the meaning of the state health department permit for the camp, which is usually in a conspicuous place. Children need little encouragement to form camp committees for the purpose of keeping the grounds clean. When given responsibility they usually work like beavers.

From the sanitary needs of a small group it is just one step to those of the larger group, the community in which the camp is located. In camps it is often easy to lose sight of this. The nurse can help bring about an interest on the part of the campers in the community—its health regulations and other interesting facts. And surely it is important for social health that the children have an opportunity to learn to know this community—perhaps to share with their neighbors some of their festivities. One camp invites the neighbors to a party given at the close of the season.

#### HEALTH ACTIVITIES

If it is customary for the counselors to present their special fields at a campers' meeting, the nurse should at that time offer to give the children health activities which they want. She might suggest a number of possibilities such as discussions on first aid procedures and equipment, and on what the body

is like and how it works, leaving the way open for the children to come to her with any health problems they may have. The important thing is to give children what they want, what they are ready for.

One interesting group of girls around twelve years came to me for information on reproduction. When I asked them what they wanted to know about they were very self-conscious. Finally one girl spoke up and said, "We know what we want to know but we haven't got the words to say it." So we started building up a vocabulary about the anatomy and physiology of the reproductive system. It was fascinating to see how they lost their self-consciousness when they had "the words." And it was interesting to see how much misinformation they had picked up.

The planning of Sunday night suppers, which in some camps the children themselves prepare, can be a natural means of teaching them what a balanced meal is. The other meals should be so well planned from a nutrition standpoint that the children, by enjoying them, unconsciously learn good habits of eating.

One important phase of camp hygiene is avoidance of the overstimulation that frequently occurs when many children are together. Quiet activity of one-half hour before meals, with a rest of an hour or more in the afternoon, usually helps to curb this. High, shrill voices in the dining room are usually an indication of this overstimulation.

Another important phase of the work of a health counselor in camp is teaching children in a matter-of-fact way to report early symptoms of colds and other illnesses. Children usually cooperate well and are objective about this, espe-

cially if the emphasis is upon reporting illnesses for the purpose of protecting the health of the group. It seems to be less difficult for a child to say "I think I'd better let you look at my throat so that you can see if it's all right for me to be with the others," than to say "I don't feel well—my throat hurts." It is interesting to see how children at camp can acquire a wholesome group health consciousness so necessary for healthful group living.

Children must also learn to take responsibility for reporting minor injuries, abrasions and the like, so commonly acquired in outdoor living. Children, at least those from the age of nine, should be permitted to do the first-aid treatment of most of these injuries—with supervision, of course—for that should be part of realistic learning in camp living. It is surprising how meticulous children can become in aseptic technique. Furthermore, the antiseptic is usually less painful when self-applied.

There are many other important phases of camp hygiene, such as the care of the sick child in camp, and the relation of the nurse to the doctor consultant.

At the close of camp the nurse should make a concise written report to the director about any significant health incidents happening to individual children, such as minor illnesses or accidents. The director will pass these on to the parents. Suggestions for hygiene or advice that parents consult the doctor about some particular health problem may also be included.

Camp is an ideal place for meeting health needs of children—physical, mental, social, and emotional—and the nurse health counselor has a significant part in this work.



# Camp Nursing in 1942: A Survey

BY DOROTHY E. WIESNER AND HELEN F. LEIGHTY, R.N.

**C**HILDREN'S summer camps have been making rapid progress in developing a program that will meet the total needs of the child. It seems important to evaluate the place of the nurse in this program.

During recent years it has been increasingly difficult to interest adequately prepared nurses in camp nursing. The war situation has emphasized this difficulty. In searching for a solution to the problem the great need for standards for camp nursing became evident. The lack of factual information necessary for the establishment of such standards was also apparent.

A Committee on Camp Nursing of the School Nursing Section was organized by the National Organization for Public Health Nursing in January 1941 for the purpose of studying the problems in this area. In the formation of this committee and in its activities every effort was made to get a wide geographical representation in order to cover the national aspects of the problem. As a first step toward the objective of the Committee, a survey of camp nursing policies and practices throughout the country was made.

With the help of the American Camping Association and a number of nurses' professional registries, who assisted by sending out the four-page schedules to summer camps, 63 usable replies were secured for analysis. Camp directors wrote 37 of these, individual nurses, 21. The remainder were from the nurses' registries themselves and from one city council on camp nursing. The differences in point of view between camp directors and nurses will receive special comment. Twenty-one states and Canada were represented. Replies from

Y.M.C.A. and Y.W.C.A. camps numbered 16; from Boy Scouts and Girl Scouts camps, 10. Other agencies such as the Salvation Army, Camp Fire Girls, boys' clubs, settlements, and churches contributed most of the rest.

The camps varied in size from one with a capacity of 50, to one Toronto-serving camp accommodating 1156 campers at one time. More than half handled less than 125 at a time. Only nine had a capacity of 200 or more. Both girls' and boys' camps were well represented, as well as a few taking both boys and girls, or mothers and children, or a variety of such groups at separate times.

A centralized camp was defined as one having program, buildings, and facilities functioning as a unit, and this type proved more usual among the individually owned and managed camps. Among social agency camps, the decentralized camps about equalled the centralized in number.

About half the camps ran an eight-weeks' season, the remainder varying from four to eleven weeks. Privately owned camps for the most part kept their campers all season. Social agency camps apparently kept their campers only two weeks—some even shorter periods.

The remuneration of camp nurses varied from maintenance only to the largest salary reported, \$250 to \$300 a season, plus board, room, and laundry of uniforms. Only four camps paid \$200 or more. Three gave maintenance alone. The median salary for the season was about \$120, social agency camps making a slightly better salary showing than private camps. Camps with larger

capacities on the whole paid better salaries, the median minimum salary among 31 camps with capacities of less than 125 campers being \$98, and among 24 camps accommodating 125 or more, \$152. Both camp directors and camp nurses were in substantial agreement that \$176 for a two-months' season was a satisfactory monthly salary.

Graduation from a state-accredited school of nursing, almost all agreed, was a desirable requirement for a camp nurse, but state license not so important. A check list of postgraduate courses, including the subjects public health, child development, psychology, health education, nutrition, camp administration, and "other," was a part of the schedule. Postgraduate education in public health was checked the most times by those who replied; camp administration, the least. Other postgraduate education courses mentioned as desirable included first aid, pediatrics, mental hygiene, and care of physically handicapped.

Of three types of professional experience, school and camp nursing were deemed equally desirable, but only 19 of the 63 indicated visiting nurse experience to be of value. Specialized work of various types with children was mentioned as important.

Of other experience—as camper, counselor, teacher, recreation worker, and "other related"—camping experience was rated highest. Camp counselor experience was looked upon as next most desirable, with recreation work third. Many schedules reflected a feeling of need for interest in children on the part of the camp nurse. She should be "attractive to children," have hobbies of interest to children, have a well rounded personality. Only one demurred enough to write, "Not too many related experiences, because camp nursing is a full-time job."

The age of the nurses employed ranged between 20 and 50 years, and

those replying were not in agreement as to any ideal age. Some preferred nurses under 30, some over 35. The word "mature" was also used to describe the preferred age.

The work of the nurse is of course dependent upon the responsibilities carried by the camp physician. Eleven of the camps had resident physicians; a few had part-time service. In the majority, however, physicians were on call. In all such cases, the nurse presumably worked under the physician. In almost every instance she had charge of the infirmary, she inventoried the health of campers on arrival at camp, and handled first aid and "sick calls." These three items were ranked in the order given.

So far as administrative work is concerned, the camp nurse was reported more active in program-planning than in advising on menus or supervising sanitary control of grounds or kitchen or toilet. In regard to "other administrative functions," a number of interesting items were mentioned—activities for prevention of illness and accidents, attending pre-camp and counselors' meetings, reporting health work to the director, planning infirmary equipment, securing suitable diets for sick children, making nightly rounds, control of mosquito and fly hazards and poison ivy growths.

As to wearing a uniform, 17 replied that this was not required. In the camps requiring that the nurse wear a uniform, the number of hours for wearing it varied from six to eleven hours a day. In about half the camps the laundering of nurses' uniforms and personal clothing was done at the camp.

There was wide variation about hours off between 7 a. m. and 9 p. m. Whatever her scheduled time off, the nurse was usually on call, available in case of accident, infirmary work, or other emergencies.

The schedule listed certain conditions

as possible problems in securing camp nurses. These were checked by those who replied, in the following order: Low salaries was the problem most frequently indicated by both camp directors and camp nurses. Second was the seasonal employment factor, indicated more frequently by camp directors than by nurses. Lack of adequately prepared nurses came next in the minds of both groups. As far as long hours of work and lack of off-duty time are concerned, nurses appeared to have more definite reactions here than camp directors, according to the relative number of times these items are checked by nurses and directors.

Other problems suggested indicate by implication that some directors do not understand nursing standards. One director said the nurse feared taking responsibility. One nurse found it difficult to secure medical advice. Another wrote bluntly, "Directors of camps should be educated to understand nursing standards." One director stated that a lack of special quarters for the nurse was a problem. Three directors found difficulty in securing nurses with suitable personalities. On the other hand, one nurse said she thought the camp nurse must be integrated completely into camp life, and should not be merely the recipient of all complaints.

One can picture interesting debates between camp directors and camp nurses from the findings in this section about "problems." It is evident there are camps and *camps*, nurses and *nurses*.

Interesting comment at the end of the four-page schedule concerned chiefly nurse personalities and educational background. Three nurses said that universities or schools of nursing should teach camp nursing. Directors were more concerned that camp nurses should be coöperative, understanding of camp life and ideals. Scarcity of medical and nursing personnel because of the war and the possibility of using "aides" and practical nurses were also mentioned.

It is believed the findings from the 63 replies are significant in focusing attention upon present-day problems in camp nursing. Gratitude is accordingly due the directors and nurses who took the time to write out their experiences and opinions. Forty-six of the 63 wished to take part in further study of camp nursing. The N.O.P.H.N. Committee on Camp Nursing hopes to progress toward establishing standards for camp nursing, and will be glad to learn of other camp directors and camp nurses interested in this endeavor.

Presented before the N.O.P.H.N. Round Table on The Nurse in Camp, Biennial Convention, Chicago, Illinois, May 21, 1942.

#### CONVENTION PAPERS SCHEDULED FOR EARLY PUBLICATION

##### AUGUST

- Nutrition: Today and Tomorrow—Marjorie M. Heseltine
- Nurse's Role in Preventive Industrial Health—Orlen J. Johnson, M.D.
- An Understanding of Health in Nursing—Ruth Weaver Hubbard
- New Ways of Teaching Health in Nursing—Dorothy Rusby

##### SEPTEMBER

- Implications of Astoria School Health Study—George M. Wheatley, M.D.; Alice H. Miller
- The College Nurse in the War Effort—Fern A. Goulding

A number of other papers will be published in early issues.

## What Makes a Good Camp Nurse?

**W**HAT makes for a good camp nurse, and the problem of finding a qualified camp nurse in wartime were topics discussed by Helen Ross of Chicago at the Biennial Convention round table on "The Nurse in Camp." In previous years excellent graduate nurse assistance has been secured from the professional placement bureaus. This year, however, many nurses who have served in camps have entered the military service, and difficulty is anticipated in securing qualified nurse service. Miss Ross has been director of Camp Kechuwa, a summer camp for girls, for 29 years.

Her discussion was divided into two parts: (1) what the director wants from the nurse at camp (2) what the nurse has a right to expect from a camp director. The need for basic nursing preparation was stressed as a first qualification. To this should be added experience with children and particularly a knowledge of communicable diseases. For example, a nurse highly trained in surgical work might not recognize impetigo. School nurses because of their experience with children and possibly because of their imperturbability in the face of many impatient children all wanting attention at once made good camp nurses. The camp nurse must have a proper balance between dependence on herself and dependence on the physician. She should be able to give hay fever inoculations and other routine hypodermic treatments prescribed by the children's physicians.

The good camp nurse should have a real knowledge of the emotional health and life of children because some children are sicker than they appear to be and some seem sicker than they are. Although the camp nurse has an understanding of children and tenderness to-

wards them she must be impartial, and not give too much attention to the attractive children. Sharpened intuition is a helpful tool for the camp nurse.

Besides these qualifications the camp nurse should be emotionally stable. While she enjoys her work and is fond of children she must not depend on them for her own emotional satisfaction, and she must be a lively, healthy, humorous person who enjoys camp life. Her work will be enhanced by her acting as an integral member of the camp staff, attending all counselor meetings whether on health or other subjects. It is unfortunate to have the camp nurse isolated in the infirmary. She should understand the purpose and ideals of the camp and know all about camp activities. At camp meetings she should be able and willing to make suggestions on health problems. She must teach, not so much by formal class work as by her attitude. The infirmary or health cottage should be in the central part of the camp. A small Franklin stove in the nurse's sitting room, around which any small group could sit on a cool afternoon or evening, proved a good investment in one camp. The camp environment, plus the quiet, friendly atmosphere of her quarters in which the warmth of the nurse's personality had attracted the children, furthered the health work.

It is taken for granted that the nurse will be capable in first-aid activities. The keeping of health records is also of importance. When there are accidents, data about them should be kept accurately so that the physician can know exactly what happened. Calling attention to the place of accident helps to avoid similar mishaps in the future.

What should the nurse expect from the camp director? The following es-

*(Continued on advertising page 7)*

# The Nurse Looks at Eye Problems in Industry

By ELEANOR W. MUMFORD, R.N.

**I**NDUSTRY is only beginning to realize the scope of the eye problems which it must meet if employees are to work in safety and with the most efficient use of sight. The need for safety of eyes in industry has been emphasized for years, yet many eyes are still lost either because adequate protection is not provided or because it is not used. There is also increasing recognition of the important part light plays both in the prevention of accidents and in the efficiency of visual effort. More recently we are coming to realize a new concept—that vision is a complex function, and that some kinds of work require a high standard of performance in one aspect of eye functioning, some in another or others, and a few probably in all.

For example, it is obvious that the ribbon clerk in a store must have ability to perceive color, but her visual acuity and muscle balance need not necessarily be perfect. On the other hand, the railroad engineer needs good distance visual acuity; he needs muscle balance to give him depth perception which will enable him to judge distance accurately; he must also have color vision or he will fail to recognize the colored signals.

Industry is also taking an increasing interest in the underlying causes of eye difficulties. Diminishing sight in a skilled worker may mean a total loss to industry of the investment it has made in training that worker. Some of the factors contributing to poor sight are occupational hazards associated with certain industrial processes. Others are the eye complications of systemic disease, communicable or noncommunicable. Often, too, the economic problems of the worker enter the picture. He de-

fers treatment for his eye condition because his children must have dental care or new clothes or shoes. His nutrition is poor, either because of inadequate income or because of poor choice of food.

Which of these problems are of special concern to the nurse in industry? All are of interest to her, but her actual responsibilities will depend upon the size and type of the medical department and the organization of the safety program in her plant.

## CARE OF EYE EMERGENCIES

One very important aspect of the safety program is the first-aid service. This is often a direct responsibility of the nurse, and it presents many opportunities for teaching safety, but it also presents hazards. Nurses often find that they are expected to undertake procedures which should be done only by a physician. The wise nurse fortifies herself with explicit standing orders as to what she is to do in given types of emergencies, especially if there are times when no physician is present. It is highly desirable that the sections of these standing orders applying to eyes be approved by a panel of ophthalmologists. However, nurses are sometimes asked even by physicians to use procedures for which they have not had adequate preparation. This is particularly true in the care of eye emergencies, since many nurses have had little or no experience in the nursing of eye conditions. The nurse finding herself in this position would do well either to request adequate training or to decline to accept a responsibility for which she is not fitted.



It is important for the nurse to keep accurate and detailed records of eye emergencies, even of dust in the eye. Here lies the door to a safety program. If the safety committee and management are impressed with the amount of time and money lost because guards and goggles are inadequate or not properly used, action is likely to follow. This means that a record should be made of every eye patient treated in the first-aid room—his name, department, and type of work; the time when the accident occurred; lost time, including time to go to the first-aid room or to the doctor; and the use and type of goggles, if any.

With such information the nurse knows which departments—even which machines—are causing eye injuries. She is in a position to advise on the necessity for more rigid requirements for goggles.

In some plants the nurses are responsible for the goggles program—fitting, cleaning, and repairing. In undertaking a goggles program the nurse is under obligation to learn as much as possible about them—the types suited to various kinds of hazards, how to fit them, how to clean them, and arrangements for prescription lenses. Even when the nurse does not have to handle the details of this program, she should inspect the goggles of men coming to the first-aid room with eye injuries. Are the goggles scratched or splotched with some substance which diminishes visibility? Are they straight and do they fit? Referral of the worker to the proper person to correct difficulties may make the difference between goggles' being worn and not being worn.

#### INDUSTRIAL LIGHTING

Nurses cannot be expected to have sufficient knowledge of lighting to give expert guidance in regard to industrial lighting. However, they can and should know enough about the principles to be alert to examples of poor lighting. Aisles,

corridors, and steps which are dimly lighted are frequently the cause of accidents. Also, a glaring light within the field of vision may lead to accidents. The records the nurse keeps of accidents lead her to investigate such conditions. Furthermore, if many employees from certain departments come to the health service complaining of what they call eyestrain or with the symptoms one commonly associates with eye fatigue, the nurse should be interested to investigate the working conditions in that department. Is a type of work conducted there which requires long periods of close eye work? If so, does the lighting appear to be adequate and comfortable? Is it directed on the work in such a manner that the worker does not have to look at a bright light? Are there reflected glares? An expert may need to be called in to remedy conditions, but the alert nurse can often call attention to the lighting conditions which lead to inefficient work and to fatigue.

The nurse also recognizes the importance of brief rest periods for workers who do close eye work. She explains to them that merely raising their eyes from their work and looking into the distance relaxes the eyes and puts the eye muscles at rest.

#### VISION TESTS IN INDUSTRY

With growing recognition of the importance of different aspects of sight in certain types of work has come an effort to include, in the pre-employment physical examination, tests which will help classify the visual aptitudes of workers. Here again the nurse finds herself called upon to help. Sometimes her responsibility in such tests is solely the giving and recording of a Snellen test, and the physician makes the other visual tests such as those for muscle balance, depth perception, fusion, and color vision. On the other hand, some nurses are being asked to do all of these tests. In order to give any tests of vision, it is necessary

for the nurse to acquaint herself with the tests, to know what aspects of sight each measures, and to know the limitations of the tests, and the factors—both physical and psychological—which affect the results.

In some industries, the nurse plays a major role in the follow-up of physical examinations and of vision tests. She may have to interpret the findings to the worker. She may need to help him know where and how he can get the necessary follow-up examinations or treatment. Thus she must know her community and state resources.

In the effort to stimulate the worker to carry out the doctor's recommendation, visual materials such as posters and pamphlets are of help. However, the nurse should review the pamphlets before presenting them to the worker to be sure they are applicable to his needs and will be intelligible to him. Of course, pamphlets cannot take the place of verbal explanations.

#### EYE COMFORT IN HEALTH OFFICE

Occasionally a nurse has the opportunity to make suggestions regarding the construction, painting, and equipping of a new health station. In this she must consider her own eye comfort as well as that of her patients and she must also consider efficient illumination for special types of work. Only a few principles can be enumerated here. All wall surfaces, doors, ceilings, and floors should have dull surfaces. A dark floor is preferable to white tile. The upper walls and ceilings should be painted a light shade while the wall below the eye level may be slightly darker. The higher the windows are placed the more light they give. Window shades which dif-

fuse the light are often preferable to Venetian blinds.

In the waiting room especially, overhead lights should be equipped with devices for softening the light. These may be made of metal, reflecting the light to the ceiling, or they may be of some plastic or glass material which diffuses the light. The goal is illumination which is free from glare. In the treatment room, overhead light should be supplemented by a floor lamp with a direct light which can be raised and lowered easily. At the nurse's desk, a semi-indirect lamp is often needed. Pin-up lamps are usually satisfactory for this purpose.

Eye problems loom large in the experience of the industrial nurse. Only a few which are common in all types of industries have been mentioned here. As previously indicated, certain industrial processes constitute hazards to sight either through direct accident or through indirect damage due to various systemic poisonings and diseases. Fundamentally there is but one approach. The nurse must learn the eye problems in her plant. She does this in several ways. She keeps careful records of all accidents and illness and asks repeatedly, "How and why did this happen and how could it be prevented from recurring?" She is aware of the factors which make for comfortable and efficient use of the eyes and is alert to conditions which lead to fatigue, strain, and accidents. She soon finds her opportunities as a teacher of health and uses all methods to present positive health instruction.

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Presented before the N.O.P.H.N. Round Table on Industrial Nursing, Biennial Convention, Chicago, Illinois, May 18, 1942.

## Report of the N.O.P.H.N. Sections

THESE reports of the three Sections of the National Organization for Public Health Nursing, covering highlights of Section meetings and activities at the 1942 Biennial Convention in Chicago, Illinois, were read at the closing business session of the Organization on May 22. Complete reports of the work of the Sections for the last biennium were published in the Biennial Report of the N.O.P.H.N., which was sent to its members. Copies are available upon request.

### SCHOOL NURSING SECTION

THE MEETINGS of the School Nursing Section at the Biennial Convention were well attended and the participation of groups at the round tables indicated great interest in the subjects under discussion.

The round-table on the Astoria School Health Study was especially significant. This study and the ways in which it is changing not only procedures but attitudes of teachers, nurses, physicians, parents, and children were described, together with an interpretation of its significance to health education.

Supervision in school nursing as conducted on a state level, in a county health department, and under a non-official urban agency, was discussed in a lively round table on this subject. The audience indicated particular interest in school nursing as a part of a general public health nursing service.

"The Nurse in the Teachers' College" and "The College Nurse in the War Effort" were subjects of papers at the round table on college nursing.

The survey of camp nursing made by the N.O.P.H.N. Committee on Camp Nursing was summarized at the round table on this subject. The camp director's part in obtaining desirable health conditions and facilities, and the nurse as health counselor in camp were discussed.

The business meeting was held at the time of the Section's luncheon at the Palmer House on May 20. Reports of the various committees of the Section—which are summarized in the N.O.P.H.N. Biennial Report for 1940-1942—were given. The future of the Joint Committee on Lay Participation in School Nursing was discussed, since several of its members have resigned because of responsibilities in connection with the war. The group thought that the preparation of the pamphlet "The Nurse in the School Health Service" on recommendation of this Committee was a major contribution to the field of school nursing and school health administration; and that lay participation in school nursing is if anything more important now than ever before. It voted that the Committee be continued as an active body with replacement of personnel as needed.

Important trends and goals in school nursing were presented by Edna Lewis, director of public health nursing at Loyola University.

Some necessary revisions in the Section constitution and bylaws, which had been previously mailed to members by the Committee on Revisions, were passed.

Two pre-convention conferences, one on elementary schools and one on sec-

ondary schools, had been planned, but these were merged into one because of limited registration.

The Section expresses to the N.O.P.H.N. staff its appreciation for the work which they have done in the interest of school nursing. The many

articles which appear in the magazine, the services of the secretary who is a member of the staff, and the printed materials on this field which appear from time to time, are but a few of the benefits which the Section derived from the National during the biennium.

#### EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

*Chairman*—Mellie F. Palmer, R.N., Peoria, Ill.

*Vice-Chairman*—Gertrude E. Cromwell, R.N., Des Moines, Iowa

*Nurse Directors*—Evelyn A. Ellingson, R.N., Lansing, Mich.; Fern A. Goulding, R.N., Ames, Iowa; Grace M. Lawrence, R.N., Newton, Mass.; Kathleen M. Leahy, R.N., Seattle, Wash.

*Non-Nurse Directors*—Ellen C. Potter, M.D., Trenton, N.J.; Dean Franklin Smiley, M.D., Ithaca, N.Y.

### INDUSTRIAL NURSING SECTION

THE pre-convention group conference on industrial nursing met with an enthusiastic response. Although registration had been limited to 30-60 nurses, 75 attended the opening session on Saturday morning; 86 came to the afternoon meeting; and 93 were present at the Sunday morning meeting on the use of public health nursing agencies for part-time service to small industries. Two hundred and fifty people attended the luncheon on May 18, and 100 more came in later to hear the speaker.

At the business meeting following the afternoon session it was voted that the Section continue its project of collecting typical records of industrial nurses with the end of formulating a set of industrial nursing records which can be suggested to new industrial health services that ask for help. Although the response has been somewhat slow, we were encouraged by some nurses who volunteered to assist by supplying records to the Section.

In the recommendations of the American College of Surgeons for minimum standards for an industrial hospital, a registered nurse is not required. One of the objectives of the Industrial Nursing Section for the near future is to get

in touch with the American College of Surgeons to see if they will insert in their minimum standards for medical service in industry, "the employment of a registered nurse."

Up to this time we have not charged a registration fee for the pre-convention group conferences. Now we have shown what we can give. Industrial nurses have responded with great interest. We feel that we should now stand on our own feet and contribute to the expense of these institutes. Following the discussion, the majority of members attending were in favor of paying a fee, but no specific amount was mentioned.

The Industrial Nursing Section has participated in the development of institutes for industrial nurses on the prevention of blindness. Articles on subjects pertaining to industrial health and safety appear regularly in *PUBLIC HEALTH NURSING* as a result of the Section's interest.

The objective of the Section is to stimulate interest in the special problems of the industrial nurse and to provide future forums for the discussion of such problems. The Section earnestly solicits the interest and support of all the members of the N.O.P.H.N.

## EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

*Chairman*—Mrs. Christian Seabrook, R.N., Chicago, Ill.

*Vice-Chairman*—Phoebe Brown, R.N., Milwaukee, Wis.

*Nurse Directors*—Marion G. Dowling, R.N., Ridgefield, N.J.; Grace M. Heidel, R.N., Albany, N.Y.; Marion Louise Hitchcock, R.N., Springfield, Mass.; Joanna M. Johnson, R.N., Milwaukee, Wis.; Mrs. Hazel H. Leedke, R.N., Kaukauna, Wis.; Ruth M. Scott, R.N., Indianapolis, Ind.

*Non-Nurse Directors*—John J. Bloomfield, Bethesda, Md.; William H. Cameron, Chicago, Ill.; Joseph M. Conway, Green Bay, Wis.; Lieutenant Commander Leonard J. Goldwater, M.D., New York, N.Y.; Crit Pharris, M.D., Hartford, Conn.

## BOARD AND COMMITTEE MEMBERS SECTION

OVER a hundred board members, representing 19 states and 44 agencies, registered at the Biennial Convention. The program planned by our able program chairman, Mrs. Langdon T. Thaxter, with the cooperation of the N.O.P.H.N. staff, proved of great interest to us all. We had three general round tables, on publicity, fund-raising, and social sensitivity. In addition, we had a very successful dinner with Samuel A. Goldsmith, executive director of The Jewish Charities of Chicago, as speaker. And a delightful tea was given us at the Historical Society in Lincoln Park, by the board members of the Visiting Nurse Association and the Infant Welfare Society of Chicago.

Four round tables for agencies of various sizes were held on "Adjusting to Present-Day Problems," and the consensus was that they were far too short.

One recommendation was that there be more round tables, that they cover a narrower field and be on specific problems of great immediacy to board members. We were particularly gratified to have a joint meeting with the National League of Nursing Education, sponsored by its lay advisory committee, on "How the Layman Can Promote Better Nursing Education." Such joint meetings strengthen mutual understanding, and it is hoped that more will be held in the near future.

At the business meeting it was decided to change the rules to enlarge the membership of the executive committee for a wider geographical representation. The members of the committee express appreciation for the work of the staff, and earnestly hope that the committee can be more helpful in the future in furthering the work of the N.O.P.H.N.

## EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

*Chairman*—Mrs. S. Emlen Stokes, Moorestown, N.J.

*Vice-Chairman*—Mrs. Langdon T. Thaxter, Portland, Me.

*Lay Directors*—Mrs. Louis L. Coudert, Hartford, Conn.; Mrs. Wilkes P. Covey, Minneapolis, Minn.; Mrs. Philip Eiseman, Cambridge, Mass.; Mrs. Francis Gilbert, Woodmere, Long Island, N.Y.; Mrs. Austin T. Levy, Harrisville, R.I.; Mrs. Richard P. Nash, South Euclid, Ohio; Mrs. Murray Rushmore, Plainfield, N.J.; Mrs. Charles E. Rolfe, Hamden, Conn.; Mrs. Sumner Spaulding, Beverly Hills, Calif.; Mrs. J. Randolph Tobias, Savannah, Ga.; Mrs. Roger Young, Newark, N.J.

*Nurse Directors*—Anna Heisler, R.N., Bethesda, Md.; Ann S. Nyquist, R.N., St. Paul, Minn.; Ruth E. Phillips, R.N., Alexandria, Va.; Marguerite Prindiville, R.N., Tuckahoe, N.Y.



# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

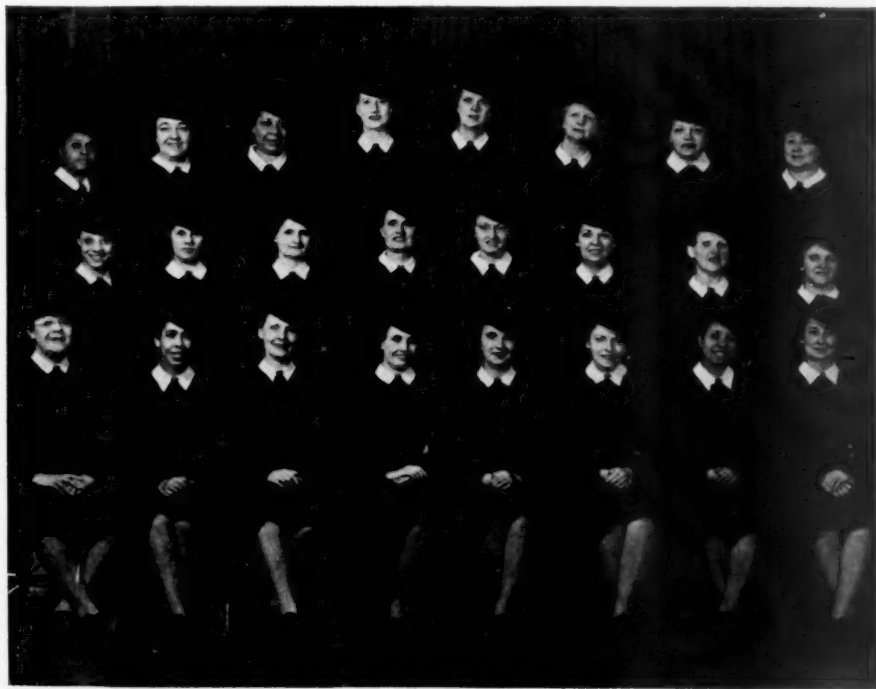
## RALLY CELEBRATES OUR THIRTIETH BIRTHDAY

THE serious tone of this year's Biennial was lightened during the Membership Rally luncheon—always the gayest and most informal event of the convention. Nearly 700 nurses gathered to commemorate the founding of the N.O.P.H.N. in the city of its birth. The guests overflowed into the adjoining corridor and the 26 states responding to the roll call of membership chairmen evidenced the wide representation of the members. Graciously presiding was Mrs. John A. Haskell of Kansas City, associate chairman of the Membership Committee, and 28 charter members were seated with her at the speakers table. Blue-covered pocket

memorandum books inscribed in silver, "N.O.P.H.N. 1912-1942," were souvenirs and our new streamline silhouette nurse made her debut on the cover of the Membership Rally folder.

Telegrams of greeting on the Organization's thirtieth anniversary from Mrs. Eleanor Roosevelt and Mrs. Chester C. Bolton were read. Singing telegrams from Mrs. August Belmont and Mrs. Bolton added further good wishes.

The marching music and ringing songs of the Chicago Health Department nurses' chorus—trim in their new uniforms with visored hats—took the audience by storm. Two of their songs—words for which were written by Clem-



The birds began to sing!

entine Elliot of the New York City Department of Health—were appropriate to the thirtieth anniversary of the National Organization and the present war emergency. Repeatedly the chorus, with Daisy Sampson as soloist, responded to the requests for encores of "Recognition of the N.O.P.H.N." sung to the contagious tune of "Deep in the Heart of Texas." Only two of the many verses are given here:\*

*Membership new,  
Will help us too,  
Augmenting list of nurses.  
We must keep pace  
In this great race  
Deep in the heart of nurses.*

*We wash your toes  
And heal your woes  
The N.O.P.H. Nurses.  
We're on the go  
Through ice and snow  
The N.O.P.H. Nurses.*

Entertaining as well as informative was a skit presented by the nurses of the Visiting Nurse Association and the Infant Welfare Society of Chicago, telling the story of the founding of the N.O.P.H.N. in 1912 during a convention of the American Nurses' Association. The parts of Mary S. Gardner, Ella Phillips Crandall, Edna L. Foley, and Jane A. Delano—four of the organizers of the National Organization—were taken by Marguerite Harmeling and Estelle Dunlap of the I.W.S., and Anna Andersen and Marion Swanson of the V.N.A.

Our own Mary Gardner in person—greatly amused by the impersonation of herself—greeted the membership following the skit. In her inimitable way she described the journey from Rhode Island to Chicago—considered a very long trip thirty years ago—for which she was awarded a flag because she had traveled

the greatest distance to the Convention. She gave a message of encouragement to all public health nurses who are now active in the present emergency. To these nurses, she said, is given the task of carrying on the services of public health nursing, of maintaining high standards and high ideals during a very trying and critical period.

#### N.O.P.H.N. DINNER

THE DINNER sponsored by the N.O.P.H.N. Board and Committee Members' Section—always one of the Biennial Convention highlights—proved a delightful occasion. Over 500 persons attended this event in the Red Lacquer Room of the Palmer House, festive with the beautiful decorations arranged by the Visiting Nurse Association and the Infant Welfare Society of Chicago. Naomi Donnelley, vice-president of the Chicago V.N.A. Board, presided with great charm. A number of distinguished guests sat at the speakers table.

"Warriors All" was the subject of the evening address by Samuel A. Goldsmith, executive director of The Jewish Charities of Chicago. His talk was about people. People the world over are human beings who have quite naturally certain human needs. "First of all people want to live . . . They cry out when they are hurt. They love to live as full a life as possible in every way. They shudder at death. They hope for a better world for their children. They hate politicians. They instinctively want peace."

But hope is also important for existence. "Hope is essential. It may keep the flame of life burning even in the absence of both butter and guns. It is hope, of course, that has kept alive, under most adverse conditions, the people of Poland, Czechoslovakia, Great Britain, and China, even some undoubtedly, within Germany and Italy. For many of them, unquestionably hope is a small, flaming star, seen only occasion-

\*Copies of this song may be secured upon request from the National Organization for Public Health Nursing, 1790 Broadway, New York, N. Y.

ally and at propitious times, and oh, so far away."

Finally, besides the desire to live and the necessity for hope is a third intangible yearning which all people have, "that there should be re-emphasis on the dignity and value of the human being as such; on the capacity for a person to achieve a position in life by virtue of the values and abilities that his life expresses."

MRS. S. EMLIN STOKES, *Chairman*  
*Board and Committee Members' Section*

#### N.O.P.H.N. RESOLUTIONS

THE Resolutions Committee of the National Organization for Public Health Nursing submits the following report, including two important recommendations:

In recognition of the increasing needs of the military forces for nursing personnel, and at the same time in appreciation of the fact that this Biennial Convention has pointed out the essential importance in the war emergency of public health nursing service in defense and extra-cantonment areas, in the rehabilitation of rejected selectees, and in the maintenance of basic health services for the care of the civilian population, it is recommended that:

1. Members of the N.O.P.H.N. study carefully the guide on "Distribution of Nursing Service During War,"\* and do their part toward putting these principles into action at once in their local communities.

2. The N.O.P.H.N. go on record as advising every public health nurse eligible for military service to consider seriously where she can put her special preparation to greatest usefulness; and to make her individual choice as to where she shall serve accordingly.

We are gratified to note that the Conference of State and Territorial Health Officers in Washington, D. C., March 26, 1942, recognized, in the light of a changed national picture and urgent new needs, the importance of extending visiting bedside nursing service to those areas where organized service to meet present needs does not exist.\*\*

The membership tenders its sincere appreciation to Grace Ross, retiring president, for her four years of vigorous and creative leadership. It is also grateful for the efficient services rendered by all the members of the staff at headquarters. We realize that demands made upon them in the days ahead will be even greater because of the war emergency and reaffirm our readiness to be of assistance whenever and wherever possible.

We express our thanks to the nurses and lay members of Chicago and Illinois, our hostesses; to The Chicago Maternity Center, Michael Reese Hospital, Cook County Hospital, and Chicago Department of Health, for their demonstrations of nursing procedures; to The Visiting Nurse Association of Chicago, the Infant Welfare Society of Chicago, and the Chicago Department of Health, for their contributions to the program given in celebration of our thirtieth anniversary at the Membership Rally Luncheon, and at the banquet.

Both the lay and professional groups express their appreciation of a program which brought to us outstanding speakers who presented subjects vital to the needs of the hour and challenged us to "close the gap between the things we do and the things we say we do."

ADAH L. HERSHEY, R.N., *Chairman*  
LAURA A. DRAPER, R.N.  
HENRIETTA LANDAU, R.N.  
EMILIE G. SARGENT, R.N.

\*National Nursing Council for War Service. Distribution of Nursing Service during War. Mimeographed. The Council, 1790 Broadway, New York. March 1942.

\*\*For the full text of this recommendation see editorial, "New Needs for the Public Health Nurse," PUBLIC HEALTH NURSING, June 1942, page 291.

## N.O.P.H.N. STAFF

**T**HREE members of the N.O.P.H.N. staff who came to the Organization during the past year to assist with special projects will stay on for varied periods of time to help with important services. Mary M. Macdonald, who has been with the Joint Orthopedic Nursing Advisory Service since October 1941, will remain until the first of the year. Mrs. Sybil Palmer Bellos, who came in April to assist with a special study on nursing service in clinics and a study of typical communities in the United States that have no organized service for the care of the sick in the home, will probably complete this work in the spring of 1943. Evelyn C. Nelson, who came in January to serve as assistant for the Biennial Convention, will stay until the first of the year to serve as Book Notes' editor and acting secretary of the School Nursing Section and to assist with the general work of the Organization.

## FIELD SERVICE

A post-Biennial Convention lull in field services on the part of N.O.P.H.N. staff took place during June.

Jessie L. Stevenson and Carmelita Calderwood of the Joint Orthopedic Nursing Advisory Service of the N.O.P.H.N. and the National League of Nursing Education participated in a meeting of the Council of Allied Organizations which met at the time of the Annual Convention of the American Physiotherapy Association at Lake Geneva, Wis., from June 28 to July 3. Miss Stevenson also acted as chairman of a round table on infantile paralysis.

On June 18-19 Miss Stevenson visited students in Boston who are there on scholarships for orthopedic nursing study, and also gave a talk to students of physical therapy in the Harvard Medical School.

Ruth Houlton attended the Annual Conference of Health Officers and Public Health Nurses held by the New York State Department of Health in Saratoga Springs on June 24, and participated in a panel discussion on industrial health and the community.

On May 15 Ella L. Pensinger visited the Community Health Society of Central Delaware County in Swarthmore, Pa.

A visit for consultation on business administration was made to the Visiting Nurse Association of Trenton, N. J. on June 16 by Ruth C. Marvin.

## HONOR ROLL

Are you the one nurse who is keeping your agency off the Honor Roll? If you're holding up the 100 percent enrollment of your staff, won't you send your membership dues today and see to it that your agency is listed on the Roll of Honor?

Don't forget that any nursing staff whether of school, industry, health department, visiting nurse association, or any other organization is eligible. And one-nurse services too! Be sure to notify us as soon as your staff is 100 percent enrolled. That is the only way we have of knowing when to send your Honor Roll Certificate and to add the name of your agency to the growing list of Honor Roll agencies.

## ALABAMA

- Limestone Health Department, Athens
- \*Metropolitan Life Insurance Nursing Service, Birmingham
- \*Pickens County Health Department, Carrollton
- Coffee County Health Department, Elba
- Green County Health Department, Eutaw
- Metropolitan Life Insurance Nursing Service, Gadsden
- Kate Duncan Smith D.A.R. School, Grant
- Hale County Health Department, Greensboro
- \*Perry County Health Unit, Marion

\*Agencies which have been on the Honor Roll for five years or more.

- \*State Health Department, Bureau of Hygiene and Nursing, Montgomery
- Blount County Department of Health, Oneonta
- Lee County Health Department, Opelika
- \*Pike County Health Unit, Troy
- Bullock County Health Department, Union Springs

**ARIZONA**

- \*Chandler Public School Nursing Service, Chandler
- Clarkdale Public Schools, Clarkdale
- Phoenix Union High School, Phoenix
- Arizona State Health Department, Nursing Division, Phoenix
- Mothers' Clinic for Planned Parenthood, Tucson
- \*Yuma County Public Health Unit, Yuma
- Truxton Canon Indian Nursing Service, Valentine

**ARKANSAS**

- \*Fort Smith School Health Agency, Fort Smith
- Poinsett County Health Unit, Harrisburg
- \*Columbia County Health Unit, Magnolia
- Greene County Health Unit, Paragould
- \*Fulton County Health Unit, State Board of Health, Salem
- \*Scott County Health Department, Waldron

**CALIFORNIA**

- Metropolitan Life Insurance Nursing Service, Bakersfield
- San Mateo County Chapter, American Red Cross, Burlingame
- \*Metropolitan Life Insurance Nursing Service, Fresno
- John Hancock Life Insurance Company, Los Angeles
- University of California, Curriculum in Public Health Nursing, Los Angeles
- Madera County Health Unit, Madera
- Yuba County Junior College, Marysville
- \*Metropolitan Life Insurance Nursing Service, Oakland
- \*Metropolitan Life Insurance Nursing Service, Palo Alto
- \*Pittsburg Public Schools, Pittsburg
- \*Metropolitan Life Insurance Nursing Service, Sacramento
- \*Santa Barbara Visiting Nurse Association, Santa Barbara
- California Tuberculosis Association, San Francisco
- \*San Jose Chapter, American Red Cross Visiting Nursing Service, San Jose
- \*Metropolitan Life Insurance Nursing Service, Santa Ana
- Santa Rosa Chapter, American Red Cross, Santa Rosa
- Metropolitan Life Insurance Nursing Service, Stockton

**COLORADO**

- Adams County Public Health Nursing, Brighton

- Douglas County Public Health Nursing Service, Castle Rock
- Morgan County Public Health Nursing Service, Ft. Morgan
- \*Weld County Health Department, Greeley
- \*Johnstown Public School, Johnstown
- Prowers County Nursing Service, Lamar
- \*Bent County Public Health Nursing Service, Las Animas
- \*Arapahoe County Public Health Association, Littleton
- Crowley County Public Health Nursing Service, Ordway
- \*Pueblo School District No. 20, Pueblo
- \*Metropolitan Life Insurance Nursing Service, Pueblo
- \*Pueblo City Health Department, Pueblo

**CONNECTICUT**

- Visiting Nurse Association of Bridgeport, Inc., Bridgeport
- North Canaan Visiting Nurse Association, Canaan
- \*Cheshire Public Health Nursing Association, Cheshire
- Clinton Public Health Nursing Association, Clinton
- \*District Nurse Association of Ansonia, Derby, and Shelton, Derby
- The Public Health Nursing Association of East Haven, Inc., East Haven
- Public Health Association of the Town of Essex, Essex
- \*Public Health Nursing Association, East Hampton
- Easton Public Health Nursing Association, Easton
- Glastonbury Visiting Nurse Association, Glastonbury
- Groton Visiting Nurse Association, Groton
- \*Public Health Nurse Association, Guilford
- Hamden Public Health and Visiting Nurse Association, Inc., Hamden
- \*Salisbury Public Health Nursing Association, Lakeville
- \*Madison Public Health Nursing Association, Inc., Madison
- \*Public Health Nursing Association, Manchester
- \*Public Health and Visiting Nurse Association, Meriden
- Montville Visiting Nurse Association, Inc., Montville, Conn.
- \*Naugatuck Chapter, American Red Cross, Naugatuck
- \*Visiting Nurse Association of New Britain, Inc., New Britain
- Public Health Nurse Association of Newington, Newington
- New Preston Visiting Nurse Association, New Preston
- \*Newtown Visiting Nurse Association, Newtown
- Norwalk Health Department, Norwalk
- \*Public Health Nursing Department of the United Workers, Norwich
- Plainville Public Health Nursing Association, Plainville
- \*Portland District Nurse and Welfare Association, Portland



- \*Red Cross Public Health Nursing Service, Putnam
- Stafford Chapter, American Red Cross Nursing Service, Stafford Springs
- Metropolitan Life Insurance Nursing Service of Torrington, Torrington
- \*Community Nursing Service of the Wallingford Tuberculosis and Relief Association, Wallingford
- East Windsor Public Health Nursing Association, Warehouse Point
- Cornwall District Nurse Association, West Cornwall
- \*Visiting Nurse Association of the Town of Windham, Willimantic
- Windsor Public Health Nurse Association, Windsor
- Woodbury Red Cross Community Nurse Association, Woodbury

**DISTRICT OF COLUMBIA**

- \*Child Welfare Society, Washington
- \*United States Public Health Service, Washington

**FLORIDA**

- \*Broward County Health Department, Hollywood
- \*Metropolitan Life Insurance Nursing Service, Jacksonville
- \*State Board of Health, Bureau of Public Health Nursing, Jacksonville
- \*Metropolitan Life Insurance Nursing Service, Orlando
- Metropolitan Life Insurance Nursing Service of Pensacola, Pensacola
- Pinellas County Health Department, St. Petersburg
- \*Hardee County Health Department, Wauchula
- Metropolitan Life Insurance Nursing Service, West Palm Beach

**GEORGIA**

- \*Metropolitan Life Insurance Nursing Service, Atlanta
- Bullock County Health Department, Statesboro
- Metropolitan Life Insurance Nursing Service, West Point

**IDAHO**

- \*Metropolitan Life Insurance Nursing Service, Boise
- \*Eunker Hill and Sullivan Mining and Concentrating Co., Kellogg
- Metropolitan Life Insurance Nursing Service, Pocatello

**ILLINOIS**

- Mercer County Health Association, Aledo
- \*Metropolitan Life Insurance Nursing Service, Alton
- \*Belleville Public Schools, Belleville
- \*Bellwood Board of Education, District No. 88, Bellwood
- \*Bellwood Welfare and Health Organization, Bellwood
- \*Boone County Public Health Nursing Service, Belvidere

Henry County Sanitarium Board, Cambridge  
 Champaign-Urbana Public Health District, Champaign  
 Eastern Illinois State Teachers College, Charleston

- \*The Tuberculosis Institute of Chicago and Cook County, Chicago
- Vermilion County Demonstration Nursing Service, Danville
- Department of Public Health and Safety, Decatur
- \*Stephenson County Tuberculosis Board, Freeport
- \*Freeport Board of Education, Freeport
- \*City Health Department Nursing Service, Freeport
- \*Amity Child Welfare Society, Freeport
- \*Board of Education Public Schools Nursing, Galesburg
- Geneseo Public Schools, Geneseo
- Board of Education, Glencoe
- John Hancock Mutual Life Insurance Company, Granite City
- \*Morgan County Health Department, Jacksonville
- \*City Health Department Nursing Service, Jacksonville
- Kankakee County Tuberculosis Sanatorium Committee, Kankakee
- \*Board of Education, District 89, Maywood
- \*Wabash County Nursing Service, Mt. Carmel
- John Hancock Mutual Life Insurance Company, Cicero
- Pekin Community High School, Pekin
- \*Peoria Visiting Nurse Association, Peoria
- Livingston County Tuberculosis Association, Pontiac
- Princeton City and School Health Service, Princeton
- J. L. Clark Manufacturing Company, Rockford
- \*Whiteside County Sanitarium Board, Sterling
- \*Iroquois County Public Health Nursing Service, Watseka
- \*Lake County Tuberculosis Association, Waukegan
- \*Winnetka Family Welfare Society, Winnetka
- McHenry County Tuberculosis Association, Woodstock

**INDIANA**

- Angola City Schools, Angola
- Fountain County Public Health Nursing Service, Covington
- \*Evansville Public Health Nursing Association, Evansville
- \*Tuberculosis Association of Allen County, Fort Wayne
- \*John Hancock Mutual Life Insurance Company, Gary
- \*Lake County Tuberculosis Association, Gary
- \*Elkhart County Tuberculosis Association, Goshen

- \*Decatur County Nursing Service, Greensburg
- \*Huntington Public Schools, Huntington
- \*Indiana State Board of Health, Bureau of Public Health Nursing, Indianapolis
- \*Metropolitan Life Insurance Nursing Service, Kokomo
- \*LaGrange County Health Nursing Service, LaGrange
- LaPorte County Public Health Nursing Service, LaPorte
- Jefferson County Health Department, Madison
- Metropolitan Life Insurance Nursing Service, Marion
- \*Visiting Nurse Association of Muncie, Muncie
- \*Ball State Teachers' College Nursing Service, Muncie
- \*New Castle Public Health Nursing Association, New Castle
- \*Vermillion and Highland Townships Nursing Service, Newport
- \*Public Health Nursing Association, Richmond
- Shelby County Public Health Nursing Service, Shelbyville
- \*Terre Haute City Schools, Hygiene Department, Terre Haute
- \*Valparaiso Board of Education, Valparaiso
- Knox County Public Health Nursing Service, Vincennes

**IOWA**

- 10th Iowa District, Public Health Nurses, Algona
- Boone Independent School District, Boone
- Boone County Nursing Service, Boone
- Metropolitan Life Insurance Nursing Service, Burlington
- \*Cedar Falls Public Schools, Cedar Falls
- \*Charles City Board of Education, Charles City
- \*Cherokee Board of Education, Cherokee
- \*Visiting Nurse Association of Council Bluffs, Council Bluffs
- \*Visiting Nurse Association, Davenport
- Decorah School Nursing Service, Decorah
- Iowa Tuberculosis Association, Des Moines
- Polk County Tuberculosis Association, Des Moines
- \*Dubuque Health Department, Division of School Nursing, Dubuque
- \*Dubuque County Public Health Nursing Service, Dubuque
- District Health Service No. 5, Iowa State Department of Health, Fort Dodge
- Harlan School Nursing Service, Harlan
- \*Indianola Board of Education, Indianola
- Iowa City Public Schools, Iowa City
- State University of Iowa, Iowa City
- Bureau of Dental Hygiene, Iowa City
- Johnson County Nursing Service, Iowa City
- Greene County Nursing Service, Jefferson
- Delaware County Nursing Service, Manchester

- Jackson County Public Health Nursing Service, Maquoketa
- \*Marshalltown Independent School District, Marshalltown
- \*Community Nursing Service, Marshalltown
- \*Cerro Gordo County Nursing Service, Mason City
- Mason City School Nursing Service, Mason City
- \*Public Health Nursing Association, Muscatine
- Monona County Nursing Service, Onawa
- Red Cross School Nursing Service, Perry
- \*Oskaloosa Public Schools, Oskaloosa
- \*Waterloo Visiting Nursing Association, Waterloo
- Allamakee County Public Health Nursing Service, Waukon
- Hamilton County Nursing Service, Webster City
- Webster City School Nursing Service, Webster City
- \*Winterset Public Schools, Winterset

**KANSAS**

- \*Arkansas City Nursing Association, Arkansas City
- \*Public Health Nursing Association, Coffeyville
- \*Butler County Board of Education, El Dorado
- \*Board of Education, Emporia
- Eureka Board of Education, Eureka
- Great Bend Public Schools Nursing Service, Great Bend
- \*Wyandotte County American Red Cross Chapter, Public Health Nursing Service, Kansas City
- \*Lawrence City School Nursing Service, Board of Education, Lawrence
- Leavenworth County Chapter, American Red Cross, Leavenworth
- Marion County Health Department, Marion
- \*Newton Public Health Nursing Association, Newton
- \*Salina Board of Education, Salina
- \*Coleman Lamp and Stove Company, Wichita
- \*Wichita Public Health Nursing Association, Wichita
- \*Wichita Tuberculosis Association, Wichita
- \*Winfield Board of Education, Winfield

**KENTUCKY**

- \*Metropolitan Life Insurance Nursing Service, Hopkinsville
- \*Public Health Center, Lexington
- Spencer County Health Department, Taylorsville
- Whitley County Health Department, Williamsburg

**LOUISIANA**

- \*Baton Rouge Chapter, American Red Cross, Baton Rouge
- \*Standard Oil Company of Louisiana, Baton Rouge

Jefferson Chapter, American Red Cross  
Nursing Service, Gretna  
Ouachita Parish Chapter, American Red  
Cross, Monroe

**MAINE**

Waldo County Chapter, American Red  
Cross, Belfast  
Piscataquis County Nursing Service,  
Dover Foxcroft  
\*Hancock County Health Service, Ells-  
worth  
\*Lewiston-Auburn Chapter, American Red  
Cross, Lewiston  
\*Lewiston-Auburn Tuberculosis Associa-  
tion, Lewiston  
Maine State Bureau of Health, Livermore  
Falls Nursing Service, Livermore Falls  
District Health Unit No. 5, Maine State  
Bureau of Health, Machias  
Rockland District Nursing Service, Rock-  
land  
\*School Nursing Service, Rumford  
\*York County Chapter, American Red  
Cross, Saco  
South Portland Branch, American Red  
Cross, South Portland  
Maine Public Health Association, South-  
west Harbor  
Metropolitan Life Insurance Nursing  
Service, Waterville

**MASSACHUSETTS**

\*Arlington Visiting Nursing Association,  
Arlington  
\*John Hancock Mutual Life Insurance  
Company, Boston  
\*Cambridge Visiting Nursing Association,  
Cambridge  
\*Canton Hospital and Nursing Association,  
Canton  
Duxbury Nurse Association, Duxbury  
Gardner Chapter, American Red Cross,  
Gardner  
\*Visiting Nurse Association, Great Bar-  
rington  
\*Franklin County Public Health Associa-  
tion, Inc., Greenfield  
Metropolitan Life Insurance Nursing  
Service, Haverhill  
John Hancock Mutual Life Insurance  
Company, Haverhill  
\*Lynn Visiting Nurse Association, Lynn  
John Hancock Mutual Life Insurance  
Company, Malden  
Millis Visiting Nurse Association, Millis  
\*Instructive Nursing Association, New  
Bedford  
\*Newton District Nursing Association,  
Newtonville  
John Hancock Mutual Life Insurance  
Company, North Adams  
Northampton Visiting Nurse Association,  
Inc., Northampton  
Berkshire County Tuberculosis Associa-  
tion, Inc., Pittsfield  
\*Visiting Nurse Association, Pittsfield  
\*Community Health Association of Rich-  
mond and West Stockbridge, Richmond

Spencer Good Samaritan and District  
Nurse Association, Spencer  
\*Sturbridge Community Nursing Service,  
Sturbridge  
\*Waltham District Nursing Association,  
Waltham  
\*West Springfield Neighborhood House  
Association, West Springfield  
Winchester District Nursing Association,  
Winchester  
\*Worcester Society for District Nursing,  
Worcester

**MICHIGAN**

\*Ann Arbor Public Health Nursing Asso-  
ciation, Ann Arbor  
Benton Harbor Public Schools Health  
Service, Benton Harbor  
\*Berkley Board of Education, Berkley  
Huntington Woods School District No.  
7, Berkley  
Eaton County Health Department, Char-  
lotte  
Branch County Health Department, Cold-  
water  
\*Out Patient Nursing Service, Detroit  
\*Genesee County Health Department,  
Flint  
\*Community Health Service of Grand  
Rapids, Grand Rapids  
\*Ottawa County Health Department,  
Grand Haven  
\*Bureau of Public Health Nursing, City of  
Grand Rapids Health Department,  
Grand Rapids  
Grosse Pointe Health Department, Grosse  
Pointe  
Dickinson County Health Department,  
Iron Mountain  
Metropolitan Life Insurance Nursing  
Service, Iron Mountain  
Metropolitan Life Insurance Nursing  
Service, Jackson  
\*The Greater Lansing Visiting Nurse Asso-  
ciation, Lansing  
Alger-Schoolcraft Health Department,  
Manistigue  
Calhoun County Health Department,  
Marshall  
Ingham County Health Department,  
Mason  
\*Midland County Department of Health,  
Midland  
\*Muskegon County Health Department,  
Muskegon  
Luce-Mackinac District Health Depart-  
ment, Newberry  
Van Buren County Department of Health,  
Paw Paw  
Metropolitan Life Insurance Nursing  
Service, Sault Ste. Marie  
District Health Unit No. 5, White Cloud

**MINNESOTA**

District Office, Minnesota Department of  
Health, Bemidji  
\*Carlton County Nursing Service, Carlton  
\*St. Louis County Health Department,  
Duluth

Cook County Nursing Service, Grand Marais  
 Minnesota and Ontario Paper Company, International Falls  
 Meeker County Nursing Service, Litchfield  
 School Nursing Service, Little Falls  
 Community Health Service of Minneapolis, Minneapolis  
 Department of Preventive Medicine and Public Health, University of Minnesota, Minneapolis  
 Nopeming Sanatorium, Nopeming  
 District No. 3, Minnesota Department of Health, Rochester  
 Metropolitan Life Insurance Nursing Service, Winona

**MISSISSIPPI**

Field Unit, State Board of Health, Jackson

**MISSOURI**

Polk County Public Health Nursing Service, Bolivar  
 \*Metropolitan Life Insurance Nursing Service, Cape Girardeau  
 Pemiscot County Health Department, Caruthersville  
 \*St. Louis County Health Department, Clayton  
 Missouri State Crippled Children's Service, University of Missouri, Columbia  
 Worth County Public Health Nursing Service, Grant City  
 Jackson County Health Department, Independence  
 Jefferson City Board of Education, Jefferson City  
 \*State Department of Health, Division of Public Health Nursing, Jefferson City  
 \*Metropolitan Life Insurance Nursing Service, Jefferson City  
 Clark County Public Health Nursing Service, Kahoka  
 \*Visiting Nurse Association of Kansas City, Kansas City  
 District Health Office, Monett  
 Lewis County Nursing Service, Monticello  
 McDonald County Public Health Nursing Service, Pineville  
 \*Atchison County Public Health Nursing Service, Rock Port  
 Missouri State Trachoma Hospital, Rolla  
 John Hancock Mutual Life Insurance Nursing Service, St. Louis  
 \*Farm Security Administration, Sikeston  
 Metropolitan Life Insurance Nursing Service, Springfield  
 Grundy County Nursing Service, Trenton  
 Jasper County Health Department, Webb City

**MONTANA**

\*Metropolitan Life Insurance Nursing Service, Butte  
 \*Metropolitan Life Insurance Nursing Service, Great Falls

Ravalli County Health Unit, Hamilton  
 State Department of Public Welfare, Crippled Children's Division, Helena  
 State Board of Health, Division of Child Welfare, Helena  
 Metropolitan Life Insurance Nursing Service, Missoula

**NEBRASKA**

Lincoln and Lancaster County Tuberculosis Association, Lincoln  
 Visiting Nurse Association, Omaha

**NEW HAMPSHIRE**

Belmont School Board, Belmont  
 \*Bradford School Board, Bradford  
 Canterbury School Board, Canterbury  
 \*Ossipee Nursing Service, American Red Cross, Center Ossipee  
 Chichester School Board, Chichester  
 \*State Board of Education, Concord  
 \*Groveton Public Health Nursing Association, Groveton  
 \*Union School District, Keene  
 \*Laconia Nursing Service, Laconia  
 Loudon School Nursing Service, Loudon  
 Newbury School Board, Newbury  
 Salisbury School Board, Salisbury

**NEW JERSEY**

\*Visiting Nurse Association, Bayonne  
 \*Bridgeton Chapter, American Red Cross, Bridgeton  
 \*Metropolitan Life Insurance Nursing Service, Burlington  
 Camden County Tuberculosis Association, Camden  
 Board of Education, Clifton  
 \*Metropolitan Life Insurance Nursing Service, Dover  
 Dunellen Board of Education, Dunellen  
 \*Elizabeth Visiting Nurse Association, Elizabeth  
 Greenwich Township Board of Education, Gibbstown  
 Haddonfield Public Schools, Haddonfield  
 Hudson County Metropolitan Nursing Service, Jersey City  
 \*Matawan Public Health Association, Matawan  
 Maywood Public School, Maywood  
 \*Montclair Bureau of Public Health Nursing, Montclair  
 \*New Jersey State Teachers College, Newark  
 Visiting Nurse Association of Newark, Newark  
 Visiting Nurses' Association, New Brunswick  
 \*Anti-Tuberculosis League, Orange  
 \*Monmouth County Organization for Social Service, Inc., Red Bank  
 \*Lowe Paper Company, Ridgefield  
 \*Salem Child Welfare and Visiting Nurse Association, Salem  
 \*Salem City Board of Education, Salem  
 Dover Township Board of Education, Toms River

- \*Westfield District Nursing Association, Westfield
- \*Visiting Nurse Association, Woodbury

**NEW MEXICO**

- McKinley County Health Department, Gallup
- Lindrieth Parish Health Center, Regina
- State Department of Public Welfare, Division of Crippled Children, Santa Fe
- \*Quay County Health Department, Tucumcari

**NEW YORK**

- \*New York State Education Department, Albany
- Infant Welfare Association, Batavia
- Metropolitan Life Insurance Nursing Service, Binghamton
- Navy Yard Office of Brooklyn Visiting Nurse Association, Brooklyn
- \*Visiting Nursing Association of Buffalo, Buffalo
- Metropolitan Life Insurance Nursing Service, Cortland
- \*East Aurora Branch, American Red Cross, East Aurora
- Metropolitan Life Insurance Nursing Service, Fulton
- \*District State Health Office, Geneva
- \*American Red Cross Visiting Nurse Service, Geneva
- \*Hartsdale Union Free School Nursing Service, Hartsdale
- \*John Hancock Mutual Life Insurance Company, Hempstead
- Hornell Public Schools, Hornell
- Huntington Public Schools, Huntington
- \*Metropolitan Life Insurance Nursing Service, Ilion
- Wayne County Public Health Service, Lyons
- Franklin County Public Health Nursing Service, Malone
- \*Metropolitan Life Insurance Nursing Service, Mechanicville
- \*Millbrook Visiting Nurse Committee, Millbrook
- \*Community Service Society of New York, New York
- \*National Society for the Prevention of Blindness, New York
- Nyack Public Health Nursing Service, Nyack
- \*Metropolitan Life Insurance Nursing Service, Ogdensburg
- \*Cattaraugus County Health Department, Olean
- John Hancock Mutual Life Insurance Company, Patchogue
- \*Public Health Association of Putnam Valley and Kent District No. 1, Peekskill
- Wyoming County Public Health Nursing Service, Perry
- \*Metropolitan Life Insurance Nursing Service, Plattsburg
- \*Dutchess County Health Association, Poughkeepsie
- \*Visiting Nurse Association, Rochester
- Tonawanda Branch of Buffalo Chapter,

- American Red Cross, Tonawanda
- Rensselaer County Public Health Nursing Organization, Troy
- \*Public Health Nursing Organization of Eastchester, Tuckahoe
- New York State Department of Health
- Utica District, Utica

**NORTH CAROLINA**

- \*Metropolitan Life Insurance Visiting Nursing Service of Burlington, Burlington
- Currituck-Dare District Health Department, Currituck
- \*Metropolitan Life Insurance Nursing Service of Gastonia, Gastonia
- \*City Health Department, High Point
- \*Metropolitan Life Insurance Nursing Service of High Point, High Point
- Duplin County Health Department, Kenansville
- Davidson County Health Department, Lexington
- Lincoln County Health Department, Lincolnton
- Metropolitan Life Insurance Nursing Service of Raleigh, Raleigh
- Wilkes County Health Department, Wilkesboro

**OHIO**

- \*Metropolitan Life Insurance Nursing Service, Akron
- Alliance Chapter of the American Red Cross, Alliance
- Cleveland Child Health Association, Cleveland
- \*Western Reserve University Public Health Nursing District, Cleveland
- Division of Public Health Nursing, Columbus
- \*Metropolitan Life Insurance Nursing Service, East Liverpool
- \*Metropolitan Life Insurance Nursing Service of Elyria, Elyria (combined with Lorain)
- \*Public Health Nursing Department, Massillon City Hospital, Massillon
- Visiting Nurse Association of Ravenna, Ravenna
- Seneca County General Health District, Tiffin

**OKLAHOMA**

- Five Civilized Tribes—U. S. Indian Service, Muskogee
- \*Cleveland County Health Unit, Norman
- Seminole County Health Department, Seminole
- Pottawatomie County Health Department, Shawnee
- City-County Health Unit, Stillwater
- Harper-Woodward County Health Department, Woodward

**OREGON**

- Linn County Health Service, Albany
- Clatsop County Health Department, Astoria



- \*Deschutes County Health Service, Bend
- Coos County Health Unit, Coquille
- \*Polk County Health Association, Dallas
- Josephine County Health Unit, Grants Pass
- Washington County Public Health Department, Hillsboro
- Hood River County Health Association, Hood River
- Yamhill County Health Unit, McMinnville
- \*Jackson County Health Department, Medford
- \*Umatilla County Health Unit, Pendleton
- \*Crippled Children's Division of University of Oregon Medical School, Portland
- Portland Visiting Nurse Association, Portland
- \*Division of Public Health Nursing, Oregon State Board of Health, Portland
- Douglas County Public Health Unit, Roseburg
- \*Metropolitan Life Insurance Nursing Service of Salem, Salem
- Tillamook County Health Service, Tillamook
- Lincoln County Public Health Association, Toledo

**PENNSYLVANIA**

- \*Metropolitan Life Insurance Nursing Service, Allentown
- \*Delaware County Tuberculosis and Health Association, Chester
- Emmaus Community Nursing Association, Emmaus
- Hamburg Visiting Nurse Association, Hamburg
- Lansdale Community Service, Lansdale
- \*Latrobe Chapter, American Red Cross, Latrobe
- \*Visiting Nurse Association, Lebanon
- \*Lewisburg Community Nurse Association, Lewisburg
- Public Health Nursing Association, McKees Rocks
- American Red Cross, Montrose Chapter, Montrose
- Metropolitan Life Insurance Nursing Service, Mt. Carmel
- \*Morrisville Red Cross Community Nursing Service, Morrisville
- Metropolitan Life Insurance Nursing Service, Norristown
- Bethlehem Chapter, American Red Cross, Northampton
- \*Palmerton School District, Palmerton
- \*Public Health Nursing Association, Pittsburgh
- The King's Daughters Society, Pottsville
- Metropolitan Life Insurance Nursing Service, Richesville
- Metropolitan Life Insurance Nursing Service of Sharon, Sharon
- Metropolitan Life Insurance Nursing Service, Shamokin
- \*Uniontown Public Schools, Uniontown
- \*Chester Valley Red Cross Nursing Association, Whitford

**RHODE ISLAND**

- Warwick District Nursing Association, Apponaug
- \*Barrington District Nursing Association, Barrington
- \*Bristol District Nursing Association, Bristol
- \*Bristol Public Schools, Bristol
- \*Richmond Visiting Nurse Association, Carolina
- \*North Providence District Nursing and Tuberculosis Association, Centerdale
- East Greenwich Visiting Nurse Association, East Greenwich
- \*Smithfield Public Health League, Esmond
- Johnston School Nursing Service, Johnston
- Town of Lincoln School Nursing Service, Lincoln
- \*John Hancock Mutual Life Insurance Company, Newport
- American Red Cross, Tiverton Chapter, North Tiverton
- \*Visiting Nurse Association of Pawtucket, Central Falls and Vicinity, Pawtucket
- \*American Red Cross, Portsmouth Chapter, Portsmouth
- Davol Rubber Company, Providence
- \*Gorham Manufacturing Company, Providence
- \*Nicholson File Company, Providence
- \*Providence District Nursing Association, Providence
- \*Providence Health Department, Providence
- \*Warren District Nursing Association, Warren
- Visiting Nurse Association, Westerly

**SOUTH CAROLINA**

- Bamberg County Health Department, Bamberg
- \*Beaufort County Health Department, Bluffton
- Edgefield County Health Department, Edgefield
- \*Florence County Health Department, Florence
- \*Calhoun County Health Department, St. Matthews

**SOUTH DAKOTA**

- \*Aberdeen Public Schools, Aberdeen
- \*Brown County Health Department, Aberdeen
- Hutchinson County Public Health Unit, Freeman
- Hand County Public Health Department, Miller
- Sully County Nursing Service, Onida
- First District Health Unit, Philip
- Board of Education of Rapid City, Rapid City
- Pennington County Public Health Unit, Rapid City
- Walworth County Public Health Unit, Selby
- City Health Department of Sioux Falls, Sioux Falls

- Sioux Falls Board of Education, Sioux Falls  
 Roberts County Public Health Nursing Service, Sisseton  
 \*Board of Education of Yankton, Yankton

**TENNESSEE**

- \*Metropolitan Life Insurance Nursing Service of Chattanooga, Chattanooga  
 \*Department of Nursing Education, George Peabody College for Teachers, Nashville  
 \*Lauderdale County Health Department, Ripley  
 Hawkins County Health Department, Rogersville

**TEXAS**

- Texas State Board of Health, Austin  
 \*Runnels County Nursing Service, Ballinger  
 Texas Public Health District No. 4, Texas State Health Department, Bryan  
 Dallas Day Nursery and Infant Welfare Association, Dallas  
 \*Galveston Public Health Nursing Service, Galveston  
 \*Houston Anti-Tuberculosis League, Houston  
 \*Southern Pacific Lines, Houston  
 Polk County Health Department, Livingston  
 San Angelo Schools Nursing Service, San Angelo  
 Tyler Public Schools Nursing Service, Tyler

**UTAH**

- \*Metropolitan Life Insurance Nursing Service, Salt Lake City  
 \*Utah Tuberculosis Association, Salt Lake City

**VERMONT**

- \*Barre Chapter American Red Cross, Barre City  
 \*Brattleboro Mutual Aid Association, Brattleboro  
 \*Visiting Nurse Association of Burlington, Burlington  
 Montpelier Public School, Montpelier  
 Montpelier Visiting Nurse Association, Montpelier  
 St. Albans Schools Nursing Service, St. Albans

**VIRGINIA**

- \*Metropolitan Life Insurance Nursing Service of Alexandria, Alexandria  
 Bureau of Nursing Service, Arlington  
 Metropolitan Life Insurance Nursing Service of Danville, Danville  
 \*Fairfax County Health Department, Fairfax  
 \*Prince Edward County Health Department, Farmville  
 \*Metropolitan Life Insurance Nursing Service, Lynchburg  
 Metropolitan Life Insurance Nursing Service of Petersburg, Petersburg

- Norfolk-Princess Anne County Health District, Portsmouth  
 Metropolitan Life Insurance Nursing Service of Roanoke, Roanoke  
 \*Fauquier County Red Cross Public Health Nursing Service, Warrenton

**WASHINGTON**

- Asotin County Health Department, Asotin  
 Kittitas County Health Department, Ellensburg  
 \*Metropolitan Life Insurance Nursing Service of Everett, Everett  
 Adams County Health Department, Ritzville  
 Mason County Health Department, Shelton

**WEST VIRGINIA**

- \*Charleston Public Health Nursing Association, Charleston  
 \*Huntington Tuberculosis Association, Huntington  
 \*Metropolitan Life Insurance Nursing Service, Clarksburg

**WISCONSIN**

- \*Iowa County Public Health Nurses, Dodgeville  
 \*Walworth County Public Health Nursing Service, Elkhorn  
 Brown County Public Health Service, Green Bay  
 Wisconsin State Board of Health, Sanitary District No. 6, Green Bay  
 Dodge County Health Department, Juneau  
 Metropolitan Life Insurance Nursing Service, Kenosha  
 \*City Health Department of LaCrosse, LaCrosse  
 \*Bureau of Public Health Nursing, Wisconsin State Board of Health, Madison  
 \*Metropolitan Life Insurance Nursing Service of Marinette, Marinette  
 \*Board of Education, Menasha  
 Lincoln County Health Department, Merrill  
 \*Wisconsin Anti-Tuberculosis Association, Milwaukee  
 Neenah Health Department, Neenah  
 Clark County Public Health Nursing Service, Neillsville  
 Oconto County Public Health Service, Oconto  
 \*Metropolitan Life Insurance Nursing Service, Superior  
 State Venereal Disease Clinic, Superior  
 \*Employers Mutual Liability Insurance Company of Wisconsin, Wausau

**WYOMING**

- Board of Education, District No. 2, Casper  
 Albany County P. H., Laramie  
 \*Hot Springs County Health Department, Thermopolis

**ALASKA**

- \*Alaska Territorial Department of Health, Juneau

# NEWS

## *Highlights on Defense*

### NEWS FROM THE COUNCIL

THE TWO committees of the National Nursing Council for War Service have been very active during the past month. The National Committee on Recruitment of Student Nurses met on June 5 in New York City. This Committee's secretary, Florence M. Seder, has moved her office to the headquarters of the Council at 1790 Broadway. Miss Seder is on leave from the Henry Street Visiting Nurse Service, of which she is secretary of appointment service. Revision of recruitment material for next fall is now under way. Most of the state nursing councils have active recruitment committees, and some of them are conducting statewide clearance of applications so that every eligible recruit will be enrolled in some accredited school.

A tremendous influx of inquiries has followed upon the temporary "A" rating requested for nursing on national and local radio programs by the Office of Facts and Figures. Thousands of letters have been received nationally and answered by the Nursing Information Bureau, and hundreds came to state councils. The majority seemed to show an intelligent interest in entering the profession and gave evidence of at least minimum qualifications. The National Council collaborated with the Subcommittee and other groups in preparing and checking material for the broadcasts.

The Supply and Distribution Committee met in New York City on June 3, and a Subcommittee, appointed to work out definite suggestions for communities to use in planning to meet military and civilian nursing needs, has been working

on a program that is to be released in the near future. Katharine Tucker, chairman of this Committee, has been appointed consultant to the Subcommittee on Nursing on questions relating to the supply and distribution of nurses, thus making possible a close working relationship between the two national organizations—government and professional—on this all-important subject. Individual conferences were held at the Biennial by Elmira B. Wickenden, Council executive secretary, and Mrs. Dorothy W. Conrad, secretary of the Committee, with representatives of 37 state nursing councils to discuss their problems. Most of the state nursing councils now have supply and distribution committees.

Katharine Peirce has been lent to the Council for three months by the Visiting Nurse Service of the John Hancock Mutual Life Insurance Company. She will serve as assistant executive secretary and will carry on the correspondence with state nursing councils in relation to the general program of the Council.

Louise Kieninger, former assistant executive secretary, left on May 23 by airplane for Brazil where she is to conduct courses in nursing education in the Servico de Obras Sociais under the auspices of the Office of the Coördinator of Inter-American Affairs. Miss Kieninger has been with the N.N.C.W.S. since November 1941. She came to the Council as a volunteer and later became a regular member of the staff. She has rendered invaluable service to the Council. Because of her previous experience in nursing in Latin America, her services

are particularly needed at this important stage in the development of nursing there, and the Council relinquishes her with regret in the belief that she has a valuable contribution to make in Brazil.

The Educational Policies Committee, of which Isabel Stewart was chairman, has disbanded and turned over its activities to the National League of Nursing Education, which has a new Committee on Educational Policies in Wartime, and to the Committee on Education of the Subcommittee on Nursing.

A telegram was sent by the Council to the President of the United States on May 21 urging him to support the appropriation of \$4,000,000 for nursing education then before the Budget Commission. An appropriation of \$3,500,000 has since been approved by the House and is now before the Senate.

#### NURSE DEPUTIES

THE appointment of a nurse deputy to the chief of emergency medical service in each state and local office of the Office of Civilian Defense has been requested in a memorandum transmitted from Dr. George Baehr, chief medical officer, to every regional office of the OCD. Instructions regarding the selection of the nurse deputy and her duties are quoted from the Medical Division Memorandum on the subject:

Each state and local chief of emergency medical service should be urged to appoint a nurse deputy, and in selecting her he should consult the state or local nursing council. She should thereafter be a member of the nursing council. The nurse deputy must have organizing ability and be able to devote the time necessary for her important duties. If a nurse has been successfully carrying out the duties of a nurse deputy under some other title, a new appointment is not indicated.

The duties of the state nurse deputy are:

1. To assist the state chief of emergency medical service and the local nurse deputies in the state in mobilizing all members of the nursing profession for duty in the emergency medical service during and after an enemy attack or other wartime disaster.

2. To aid the American Red Cross and the hospitals to carry through a full program of training of nurse's aides so that the depleted ranks of hospital and public health nursing services may be assisted in carrying the heavy burden of wartime service in civilian hospitals and health departments, as well as in the casualty stations and first-aid posts of the emergency medical service.

3. To assist the state hospital officer and state chief of emergency medical service in the emergency assignment of private duty nurses, and of nurses from local and state hospitals and health agencies to base hospitals, if the need arises for the evacuation of patients from casualty receiving hospitals of the coastal cities.

The duties of the local nurse deputy are:

1. To maintain an active file of available nurses, kept up to date by, at least, a monthly checkup. A copy of the complete file should be provided by the nurse deputy for the chief of emergency medical service. Duplicate cards should be on file at registries, hospitals, or other suitable places for use in different parts of the community so that nurses may be secured for emergency duty in hospitals and casualty stations on short notice. In a large city, it is desirable to subdivide the duplicate file according to the districts or precincts in which nurses reside or work. In smaller towns or in rural districts only one file will be required.

2. In collaboration with the American Red Cross and the local chief of emergency medical service, to provide all nurses with a first-aid course and instruction in gas protection and the care of chemical casualties.

3. To arrange with local agencies employing public health nurses for home visits to (a) casualties slightly injured who have been allowed to return home without hospitalization (b) convalescent patients discharged early from hospitals to make room for casualties; and to assist the local chief of emergency medical service to arrange for centralized reporting of the need for this nursing care in homes.

4. To assist the local chapter of the American Red Cross and the local hospitals to carry through a full program of training of nurse's aides for wartime service in civilian

hospitals and health departments as well as in the casualty stations and first-aid posts of the emergency medical service.

#### NEW HOME NURSING TEXTBOOK

A NEW *Textbook on Red Cross Home Nursing*, written in a simple, popular style, yet bearing the stamp of approval of authorities in the fields of nursing, medicine, and public health, is to come off the press in July. Two million copies have been ordered by the Red Cross Nursing Service to be made available to the thousands of students,

old and young, masculine and feminine, in Red Cross home nursing classes throughout the country.

Its purpose—like the fourth edition of the *Textbook on Home Hygiene and Care of the Sick* which it replaces—is to help homemakers and potential homemakers meet personal and family health problems in their own homes. The new book, bound in the familiar gray cover with modern trimmings of red, is illustrated with 100 pictures and drawings. It will sell for 60 cents and may be procured from any Red Cross Chapter.

### *From Far and Near*

- Three new programs of study in public health nursing were approved by the N.O.P.H.N. Education Committee at its June 1942 meeting:

The University of North Carolina, Chapel Hill—Ruth W. Hay, professor of public health nursing

The University of Pittsburgh, Pittsburgh, Pa.—Dr. Dorothy Rood, professor of public health nursing

Seton Hall College, Newark, N. J.—Caroline di Donato, assistant professor of nursing education

This makes 31 approved programs of study as of June 1942.

- Dr. George S. Stevenson, medical director of the National Committee for Mental Hygiene, has been elected president of the National Health Council for 1942 to succeed Dr. Kendall Emerson. Dr. Emerson, managing director of the National Tuberculosis Association, becomes vice-president and chairman of the Executive Committee. Other officers elected are: treasurer, Dr. William F. Snow, general director, American Social Hygiene Association; secretary, Mrs. Eleanor Brown Merrill, executive direc-

tor, National Society for the Prevention of Blindness.

- Fifty years of community service are celebrated this year by the Visiting Nurse Association of Kansas City, Missouri. The organization began in 1891 when the Ladies Society of the First Congregational Church employed a nurse to work among the "sick poor." The program has broadened till today the agency serves all people in the community regardless of race, creed or economic status. The present staff includes 51 nurses. For 36 out of 50 years the V.N.A. of Kansas City has been an agency member of the N.O.P.H.N.

- The recent appointment of Dr. John Y. Battenfield as medical associate will enable the National Society for the Prevention of Blindness to work even more extensively than in the past with the medical profession and with public health agencies everywhere. Dr. Battenfield was formerly epidemiologist and director of preventable diseases in the



Oklahoma State Department of Health. He will remain in Oklahoma for a period of months working on a special trachoma control project, under joint auspices of the Society and the State Health Department.

- The University of Toledo (Ohio) on June 9 conferred the honorary degree of Master of Science on Emma E. Roberts, director of the Toledo District Nurse Association, in recognition of her unusual service to humanity. The citation in presentation of the degree read, in part: "For thirty years Miss Roberts has been a leader of good works in this city contributing especially to the field of public health . . . She has brought fame to her city and to her profession by the diligence of her leadership and she has helped to give more useful and happy lives to thousands of our citizens."

- Presentation of the Leslie Dana Gold Medal this year to Lewis H. Carris, director emeritus of the National Society for the Prevention of Blindness, brings signal honor to a man who for two decades commanded the forces fighting for eye protection in America. The medal is awarded annually for outstanding achievements in the prevention of blindness and the conservation of vision.

- The ninth annual meeting of the Association of Collegiate Schools of Nursing was held in Chicago, Illinois, May 15-16, 1942, with representatives from 19 member schools present. Four new schools were accepted into the Association, bringing the total membership to 31. The new members are University of Minnesota School of Nursing, the Russell Sage College School of Nursing, the Marquette University College of Nursing, and the University of Cincinnati School of Nursing and Health.

Various problems of nursing education in connection with the present

emergency were discussed. The following officers were elected:

President—Sister M. Olivia Gowan, The Catholic University of America, Washington, D. C.

Treasurer—Ellen L. Buell, Syracuse University, Syracuse, N. Y.

Board of Directors—Isabel M. Stewart, Teachers College, Columbia University, New York, N. Y.; Effie J. Taylor, Yale University, New Haven, Conn.

- "The Delaware Pattern for Industrial Health in Defense," was the subject of a symposium sponsored by the Public Health Nursing Section of the Delaware State Nurses Association, on the evening of May 14, 1942.

- The Conference on Human Development and Education under sponsorship of the University of Chicago, the Commission on Teacher Education of the American Council on Education, and the Department of Supervisors and Directors of Instruction of the National Education Association, will meet at the University of Chicago, August 10 through 21, not July 27-August 7, as originally announced. This conference is open to all who are interested in better teaching and instructional leadership. Write Daniel Prescott, director, Division of Child Development, University of Chicago, for program and details concerning expenses for registration and living.

#### NEW APPOINTMENTS

(For N.P.S. appointments, see page 379)

The United States Public Health Service announces the following assignments to state health departments:

#### Public health staff nurses

Nettie E. Alley, Colorado; Ada Burt, Alaska; Dorothy Cairnes, Texas; Margaret E. Higgins, Washington; Marie S. Hurt, Virginia; Esther Mautz, Arkansas; Winona Nordlind, California; Catherine W. Tinkham, Connecticut; Emma Elveda Walton, Missouri; Rae Bonitta Witt, Louisiana.

(Continued on advertising page 7)

# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*



*Courtesy United Service Organizations, Inc.*

**Vacations at Home Can Be Gay**

## Make Our Machinery Work!

**T**HERE IS a steady increase in the number of nurses reported to be required for service with the Army and Navy, the last figure being 3000 per month. As the number grows, the necessity for taxing our resources to the limit becomes more urgent.

The nursing profession itself is charged with the responsibility for mobilizing its total resources to supply the nursing needed during war for our military and our civilian populations. Such a voluntary system depends not only upon unity of purpose but on co-ordinated action to a degree far beyond anything we have ever known. Besides the will to do we need the machinery to do with—machinery so far-reaching that it encompasses every nurse in every community of the nation, and yet so closely intermeshed that prompt action is possible on a nationwide scale.

The machinery set up to mobilize nursing for the war period consists of the National Nursing Council for War Service and state and local nursing councils. In some instances community nursing councils have already existed locally, but with the change from peace to war status these were converted to councils for war service. The National Nursing Council has been in operation since July 1940, and state councils have now been formed in all of the 48 states, the District of Columbia, and Hawaii and Puerto Rico. This is just a beginning. Local nursing councils for war service, according to our latest information, are being formed in a number of states, but this is not sufficiently rapid organization considering the scope and immediacy of the job that confronts us. The combination of national, state, and local councils could be an effective channel for the distribution of nurses during war, but the efforts of the national and

state councils, no matter how competently they function, will be fruitless if we lack well-organized local councils.

In all communities which have no local councils, public health nurses must share immediately in the responsibility for organizing them. The system which we are relying upon to expedite voluntary assignment and distribution must at least be given a chance.

The alternative to a voluntary scheme developed by the nursing profession itself will obviously be some selective or compulsory scheme developed by the Government. This possibility has been widely discussed, but a draft of nurses in the military sense does not seem imminent in view of the fact that there is yet no drafting of women. The recent establishment by the President of a War Manpower Commission for bringing about the most effective use of the nation's manpower has resulted in some speculation as to whether this might conceivably be interpreted to include nursing power. One of the objectives of this Commission is stated to be "formulating legislative programs designed to facilitate the most effective mobilization . . . of manpower . . . and with the approval of the President, recommend such legislation as may be necessary."

In this issue of **PUBLIC HEALTH NURSING** under the title "Nurses, to the Colors!" (see page 471) appears a selective list of classifications of nurses, formulated by the National Nursing Council for War Service. In order to put these classifications into effect it is urged that nurses get in touch at once with the local nursing council for war service. This job of classifying nurses eligible for military service according to the categories prescribed by the National Nursing Council cannot be com-

pletely carried out unless local nursing councils are everywhere at work. And this is only one of the important jobs to be done by the nursing profession in fulfilling its responsibility for seeing to it that every nurse serves where she is most needed.

The recent national war literature is replete with diagnoses of our national morale, and more often than not the question is raised as to whether our democracy has produced an adequately disciplined citizenship capable of responsible voluntary action in the war effort. Certainly the nursing profession which represents a functional group with trained skills of great value to a nation at war can little afford any disunity or

confusion or neglect that will hamper it in carrying out its responsibility for the assignment and distribution of nurses during war. Well-organized nursing councils, local to every individual community and co-operating harmoniously with state councils and the National Council, are a basic and immediate necessity. Public health nurses should, in the communities in which they live and work, turn to account the particular aptitudes for community organization they have acquired through arduous and profitable experience. Let them without delay do everything possible to establish and activate local nursing councils for war service so badly needed.

H. H.



### NOTA BENE, SCHOOL NURSES!

**T**HE SEPTEMBER issue of PUBLIC HEALTH NURSING will be a special school number with important articles on wartime adjustments in school health programs, newer concepts of community relationships, co-operative planning, record keeping, group teaching, supervision, and other topics of interest to all nurses.

On the shoulders of public health nurses in schools today rests a grave responsibility for developing and conserving the human resources of the nation. Early correction of defects and promoting good health habits of children will raise the health status of the nation far beyond the level indicated by the number of young men rejected in the recent draft.

When the school nurse accepts this responsibility she realizes the need for using techniques known to her profession to be the best available. She needs to know the experiences of others in her field and to share with others the results of her own experience.

The National Organization for Public Health Nursing is the channel through which ideas and experiences can best be exchanged. Are you a member of your national professional organization? Are you a subscriber to the magazine? And note well, school nurses, that the staff at national headquarters is available for consultation, through correspondence or in person, on your ever-present problems. JOIN THE N.O.P.H.N.—MEMBERSHIP HELPS YOU!

# Nutrition---Today and Tomorrow

By MARJORIE M. HESELTINE

**Credits and debits in our national nutrition account and suggestions from a well-known authority as to what can be done to better the record**

AS THE word "nutrition" has come into common parlance, it has come to mean many things—all the way from diet to the general state of health. In this discussion on the general topic of nutrition and health, I am using the word "nutrition" in the sense of nutritional status, the resultant of two forces—the nutrients taken in the form of food and the processes by which the body makes use of those nutrients. With more courage than judgment I have agreed, first, to present to you what leaders in nutrition work consider our present nutritional status to be and, second, to look into the prospects for the future. I see no way of dodging a brief review of our past nutritional status because it is only by comparison of the past with the present and by weighing some of the forces now at work that we can make a halfway intelligent guess as to the future. It is not an easy job. I shall have to steer a straight course, avoiding the pitfalls of both the sociologists and the social workers. According to the social workers, you know, the sociologists don't know where we've been, and, if you will believe the sociologists, the social workers don't know where we are going.

We don't know the whole story of where we have been, nutritionally speaking—not by any means. If we look back over only the short period since the outbreak of the first World War, we cannot make a clear-cut statement as to changes in nutritional status.

In 1914, as now, physicians were able to detect well-developed cases of certain diseases associated with faulty diet, although it was not until 1915 that Goldberger proved conclusively that pellagra could be prevented and often cured by improving the diet. If we take the incidence of deficiency diseases in severe form as an index of nutritional status, the news is good. Pellagra, rickets, and scurvy are far less common now than they were a quarter of a century ago; in some parts of the country, teaching hospitals have difficulty in finding enough clinical material to familiarize future physicians and nurses with these diseases.

But we are not willing to agree that the nutritional status of our present population is satisfactory merely because few people are dying or are incapacitated by dietary deficiency diseases. Our standards are not that low! We wish to know whether we have made progress in reducing the incidence of the milder forms of malnutrition, which have probably always been more common than the severe forms. We need to know the extent to which mild malnutrition is present in the country today.

## NUTRITIONAL STATUS TODAY

Probably the best considered statement on the nutritional status of the American people is that made recently by a special committee of three appointed by the Food and Nutrition Board of the National Research Council to evaluate



existing evidence on the prevalence of malnutrition in the United States. Reporting in *The Journal of the American Medical Association* for March 21, 1942, the members of this committee, Dr. Norman Jolliffe, Dr. James S. McLester, and Dr. H. C. Sherman, concluded that severe malnutrition is not common but that the nutritional status of an appreciable part of the population can be distinctly improved. Three wise men that they are, they do not express an opinion as to whether malnutrition is on the increase or the decrease in this country. We shall do well to be equally prudent.

The techniques by which we are now able to detect the early signs of nutritional failure are new and have still to be applied widely. At the time of the last war, we didn't have slit lamps for revealing deficiencies of riboflavin and vitamin A; nor did we have tests for the ascorbic acid content of the blood. As a matter of fact, we didn't even know that riboflavin and ascorbic acid were essential to human nutrition. The existence of vitamin A and the effect of its deprivation were known to scientists, but that knowledge had not been translated into a national agricultural policy by any country. For example, Denmark allowed its dairy products to be exported to Great Britain and its children to develop vitamin-A deficiency in consequence, not because Denmark did not cherish its children but because of a general lack of appreciation of the difference in food values of butter fat and certain other table fats.

#### IMPROVEMENT POSSIBLE

Since we were not able to measure the prevalence of mild forms of nutritional failure 25 years ago, we lack a benchmark against which to compare our status in respect to those things that we can measure today. But does it really matter whether we are better or worse off than we have been? Isn't what

matters the fact that malnutrition in mild form is far from uncommon, that malnutrition in its early stages is curable, that it is preventable, and that improvement in our nutritional status is essential to full national efficiency both now and after the war is over?

It is relatively easy to see progress in some aspects of life that can be measured and that are influenced by nutrition. Take growth, for example, generally accepted as one of the best indices of healthy childhood. Boys and girls entering college today are taller and heavier than their parents were at the same age. We have the word of the War Department that young men on induction into military service are likewise bigger than the average citizen-soldier who entered the army in 1917. Comparison of the average sizes of children in different parts of the United States indicates that the largest children are to be found in the sections where the largest quantities of protective foods are consumed and, I should add, where the general economic level is relatively high. Children born to Oriental parents in California grow bigger than their cousins in the home country. Few will deny that size is fixed by heredity. Nevertheless, the child's nutrition has a lot to do with determining the extent to which he approaches the limits set by his heredity.

#### BETTER DIETS

If food is the raw material of good nutrition and if nutritional status has improved in the past 25 years, diets should also have improved. In my opinion, the evidence shows that they have improved in most respects, but not all, and for most people, but not all. I say this in the face of sensational popular articles that have flooded the press and magazines during the past year, many of them written in sincere if misguided zeal to further the national nutrition program. As the political campaigners say: "Let's

look at the record!" On the credit side, we can point to increased consumption of some of the nutritionally most important foods—milk and vegetables and fruits, especially tomatoes and citrus fruits. Someone has said that within his lifetime, he has seen an orange change from a once-a-year luxury in the Christmas stocking to a once-a-day staple of the breakfast table. No doubt he spoke figuratively, but the statement is almost literally true in many homes. The curve of milk consumption goes generally upward although it dips during hard times.

#### FOOD PROBLEMS

There is a darker side to the record of changes in food consumption, however. As more and more people in this country live in urban areas and as agriculture becomes industrialized, families are removed farther and farther from their food supply. We have tended to rely increasingly on those foods that can be transported over long distances and that can be stored with a minimum of deterioration. Refined grain products—that is, white flour and the milled cereals—sugar, and fats have made up a very large part of the total food supply, especially of the families that cannot spend much money for food. Now these are wholesome foods if they are used in addition to—and not in place of—foods that make a better-rounded contribution to the diet. A change for the worse in the diets of the babies of the country has come about through the decline in breast feeding. In partial compensation, however, we have an unquestioned improvement in general availability of safe and low-cost forms of cows' milk for babies. If, as some observers think, the decline in breast feeding has been checked and an upturn has set in, no one will deny that the lion's share of the credit belongs to the nurses of the country.

Balancing the debits against the credits in our record of food consump-

tion, it seems fair to say that we are at least as well fed as we have ever been but by no means as well fed as we might be if each of us made the best possible choice among the foods available. Some of the desirable changes in food habits call for no more effort than looking at the labels on the foods we buy. Enriched bread and flour look and taste the same as unenriched bread and flour; enriched bread costs no more than unenriched bread and enriched flour little if any more than unenriched flour. To the working man or active boy who gets a good part of his food energy from bread, the choice between the enriched or the unenriched form may spell the difference between enough and not enough thiamine and niacin.

Let us be as optimistic as possible and assume that as we enter the war we are as a nation as well fed as we have ever been and at least as well fed as any other nation, United or Axis. If this is true, it is an occasion for thankfulness but certainly not for complacency. We shall have to work hard to hold the ground we have gained. All of us are committed to years of hard work—physical work and mental strain. More than ever before we shall need enough of the right kinds of food. We cannot expect all future restrictions in our food supply to be—like sugar rationing—the answer to the nutritionist's prayer. We can, however, take comfort that as we have to make substitutions we can make them with fuller knowledge of nutritive equivalents than ever before.

The experience of thickly populated islands that have been first to feel food shortages bears testimony to the practical value of research on vitamin content of foods. Both Great Britain and Hawaii have had to seek new sources of ascorbic acid because shipments of oranges are no longer received in sufficiently large quantities. Hawaii is turning to guavas and papayas; Great Britain to black currants and a syrup

made from rose hips. In passing I may say that the rose hips were collected by Boy Scouts and Girl Guides during their holidays as their contribution to the youngest of the soldiers in a total war, the babies of Britain. Now the word "substitute" has always carried the connotation of inferiority; but thanks to scientific knowledge, the British and Hawaiians have found substitutes that are several times richer in ascorbic acid than oranges themselves.

If supplies of certain foods run low—temporarily or for the duration—it goes without saying that what we have must go to those who need it most, that is, the armed forces, using that term in the broad sense to include both our combat army and our production army. There is little question that our armed forces are the best fed in the world and that they realize it, even though they exercise their inalienable right to grumble when the home-cooked touch is lacking.

#### FOOD FOR THE WORKER

One of the biggest things that could happen for the nutritional status of the people of this country would be for some genius to devise means of feeding the men and women in war industries as well as the men in the armed forces are fed. That the present situation is far from ideal is set forth convincingly in the first report of the Committee on Nutrition in Industry of the National Research Council, a report based on observations in defense establishments in widely scattered sections of the country. A few plants have the situation reasonably well in hand. Most men, however, have to eat hurriedly at their bench a packed lunch brought from home, supplemented by the beverages—hot or cold—and the miscellaneous assortment of pies and cakes dispensed in or near the plant by commercial concessionaires. It is encouraging that some plants are aware that the situation is unsatisfactory and are turning for help to industrial

hygienists and industrial nurses, who in turn are calling on nutritionists. In most cases the situation can be bettered even if it cannot be made wholly satisfactory. In one Government arsenal the Red Cross Canteen Corps has stepped into the breach; until such time as a new building containing a cafeteria can be completed, these devoted women are serving hot meals at three o'clock in the morning to the men on the "graveyard shift."

Providing a good meal at the plant is obviously only one step toward better nutrition of the industrial worker. Most workers eat two other meals outside the plant—at home, at a boarding house, or in a restaurant. The adequacy of those two meals will depend largely on the interest and skill of the persons who prepare them. In two small industrial towns in Vermont a large proportion of the workers are men living in boarding houses. The nutrition service of the State Department of Public Health inserted a modest announcement in the local newspapers, offering to supply menus to boarding houses. Requests came in by return mail. Perhaps the majority of defense workers live with their families; they eat two of their meals at home and carry a packed lunch to the plant. These workers are likely to be well fed only if the person in the family who is responsible for their food knows what they need and how to buy and prepare it and if they themselves are willing to make needed changes in their eating habits. So an educational program in foods and nutrition that reaches both the workers and their families is very much in order. In some communities nutrition committees are tackling this job with the wholehearted support of organized labor and its auxiliaries. In one plant the young women members of a local garment workers' union offered to round up their mothers for a series of lessons to be given by volunteer teachers under the supervision of the city nu-

trition committee. Industrial workers are every bit as much interested in good nutrition for themselves and their families as are the wives of prosperous professional and business men who have so often been the first to enroll in nutrition classes.

#### VITAMIN-FEEDING

Inevitably the question has arisen as to the desirability of trying to make supermen out of our soldiers and our industrial workers through vitamin-feeding. The question has been answered in part as a result of a series of studies on healthy young soldiers. These young men, while subsisting on the very liberal army ration, were subjected to vigorous exercise for periods of varying length. Then their diets were supplemented with large quantities of thiamine chloride, riboflavin, and ascorbic acid and they were again subjected to exercise. There was no indication that the supplementation had any effect on muscular ability, endurance, resistance to fatigue, or recovery from exertion. As long, then, as the standard ration is available, the army plans to rely on food, good food and lots of it.

Industrial management has heard about vitamins from reading or from enterprising salesmen. Some employers who are aware of the contribution of food to industrial efficiency but who cannot see their way clear to equipping and operating plant cafeterias have attempted the short cut of distributing vitamin preparations to their workers. Nutritionists in the health departments of states in which war industries are located report a steady flow of questions from management on the advisability of vitamin-feeding of the workers. The problem is of sufficient magnitude to call for joint action of two councils of the American Medical Association, the Council on Foods and Nutrition and the Council on Industrial Health. Their report appeared in *The Journal of the*

*American Medical Association* for February 21, 1942. Let me quote some excerpts from the concluding paragraph:

... satisfactory evidence of the wisdom of the general practice of industrial concerns providing all of their employees with vitamins indiscriminately is lacking . . . . Nothing in this report is intended to belittle the significance of vitamins in nutrition, or the value of the proper use of added vitamins in improving staple foods such as bread and flour. What is being emphasized is the need for the avoidance of indiscriminate mass use of vitamins, a practice which supports the commercial exploitation rather than the scientific rational use of these important dietary factors.

If the best judgment to date is against the indiscriminate feeding of vitamins to the armed forces and industrial workers, it is hard to find any justification for their routine use by the rest of us. Supplies of concentrated and synthetic vitamins are by no means limitless. Let us save what we have for those who do not have access to them as food.

#### FAMILY NUTRITION

What is likely to happen to the nutritional status of the rest of the civilian population in wartime? Already some people are better able to buy food and some are less able. Where there is full employment because of defense work, some of the women attending antepartum clinics can for the first time in their lives come somewhere near to carrying out the dietary recommendations made by the physician. In other words, teaching has a greater chance of effectiveness than ever before. But even in communities that are enjoying a defense boom, not all families are sharing in the prosperity. If their incomes have remained stationary while prices of necessary commodities have risen, families are worse off than ever. This is very likely to be the situation in families that are dependent on some form of public assistance, because allowances have not tended to keep pace with the increased cost of living.

Then, too, it takes time as well as

money to keep a family well fed, and time is a very scarce commodity these days. More and more women are spending long hours out of the home, either because they are gainfully employed or because they are giving volunteer service. In either case, family meals are likely to suffer. Unless there is a grandmother to take over the care of the house, the mother has either to struggle with food preparation before and after a taxing day's work or to let the children shift for themselves. Wherever large numbers of women are employed in essential war work, there is need of centers for the all-day care of younger children and for the care of children of school age after school hours and during vacations. Of course, such centers should be equipped with facilities for serving meals and should be manned with suitably trained personnel.

#### SCHOOL LUNCH PROGRAMS

If there has ever been a need for the continuation and extension of school-lunch programs, that time is now when the only alternatives for so many children are to forage for themselves at home or to squander their lunch money on unsuitable foods at a commercial eating place. Until Congress has taken final action on appropriations for the coming fiscal year, we shall not know the extent to which foods for school lunches will be available through the program of the Agricultural Marketing Administration or whether the Work Projects Administration will be able to provide the services of as many cooks and helpers for school-lunch projects as it provided last year. From the standpoint of child nutrition it is of course to be hoped that neither of these important resources will be curtailed. Forehanded communities are already looking forward to next year's lunch program and are embarking on ambitious gardening and canning projects during the summer months to

make sure that there will be local protective foods in school storerooms.

#### NUTRITION TOMORROW

The nutrition of tomorrow depends on what we do now, especially on what we do to protect the health of our children and to continue our capacity to produce the food we need. None of the implications of the examinations in connection with Selective Service has impressed me more than the comparison that Ciocco, Klein, and Palmer made between the draft findings on a group of young men rejected for physical defects and the earlier data on those same young men of Hagerstown, Maryland, from their school examination records. If you have read the report you know the conclusion that "the childhood state of nutrition was definitely associated with the development of defects that 15 years later disqualified the adult for Selective Service."<sup>1</sup> Would that have been the case if those schoolboys of 15 years ago could have had nourishing noon meals throughout the rest of their school days, if both they and their parents could have been reached by well-aimed instruction on their food needs, and if any physical defects that interfered with efficient utilization of food had been corrected? Failure in peacetime to deal with needs that were shown to exist resulted in impaired power for the defense of the country in time of war. If we can profit by that lesson from Hagerstown and if we can do our utmost to safeguard the nutrition of our children in wartime, we shall have made them just that much better able to take over their inescapable task of putting the world together again.

<sup>1</sup>Ciocco, Antonio, Klein, Henry, and Palmer, Carroll E. "Child Health and the Selective Service Physical Standards." *Public Health Reports*, December 12, 1941, page 2372.

Presented before the N.O.P.H.N. General Session on Nutrition and Health, Biennial Convention, Chicago, Illinois, May 21, 1942.



# Recent Research in Infantile Paralysis

By ALBERT MILZER, Ph.D., AND SIDNEY O. LEVINSON, M.D.

**A**LTHOUGH nearly 33 years have elapsed since Landsteiner and Popper first isolated and identified the etiologic virus of poliomyelitis, comparatively little is known concerning the exact mode of transmission, prevention, and successful therapy of this dreaded disease. Few infectious diseases have yielded less fruitful results than the study of infantile paralysis which has been carried out during the past 30 years by many competent investigators. We still lack fundamental knowledge as to the natural portal of entry of the virus before gaining a foothold in the body. The manner in which infantile paralysis is transmitted from one individual to another is unknown. There are no laboratory tests to aid in diagnosis of this disease or skin tests to determine susceptibility such as the Schick test in diphtheria. Nevertheless, definite progress has been made in poliomyelitis research during the past few years, and we propose to review some of the more significant developments.

## PROPERTIES OF THE VIRUS

Poliomyelitis is caused by a filterable virus. The term "virus" refers to that group of agents which are usually invisible under the ordinary optical microscope and which can be cultivated only in the presence of living tissue cells. The poliomyelitis virus is one of the smallest of the known viruses, its size has been estimated at approximately 10 millimicrons (ten millionths of a millimeter). The virus appears to be more resistant to physical and chemical agents than non-sporulating bacteria. It can be preserved for at least six years in 50 per cent glycerine, and is quite resistant to

drying, phenol (1 percent), ether, and gastro-intestinal juices. However, it is readily destroyed by ultraviolet rays, oxidizing agents such as potassium permanganate and hydrogen peroxide, and by heating at 60°C. for 20 minutes. Recently it has been shown that an amount of chlorine (0.5 part per million) ordinarily in excess of that used to purify drinking water failed to destroy the virus within one and one-half hours.

The virus has been concentrated and purified to a considerable degree. Schultz and Raffel at Stanford University sedimented the virus from almost water-clear infected tissue suspensions by means of an air-driven vacuum ultracentrifuge,\* operating at 30,000 revolutions per minute for several hours. Clark and his associates at the University of Wisconsin have concentrated the virus present in an infected monkey brain and spinal cord 100 to 1000 times by various chemical extraction and precipitation procedures. More recently Loring at Stanford has concentrated the virus as much as 10,000 to 100,000 times that represented in the spinal cord of a paralyzed monkey by means of a special technique known as "differential centrifugation" and has shown that the virus probably consists entirely of protein. Perhaps further research along these lines may disclose that these highly purified and concentrated virus sediments can be used to prepare effective vaccines for the prevention of poliomyelitis and antigens suitable for aid in diagnosis by laboratory procedures.

Many attempts to cultivate the polio-

\*The ultracentrifuge is a specially designed high-speed centrifuge.

myelitis virus in the usual tissue cultures and developing chick embryos have failed thus far. The only unequivocal successful results were obtained by Sabin and Olitsky of the Rockefeller Institute for Medical Research in 1936. They found that the virus multiplied in the brain and cord of young human embryos, while no growth occurred in cultures containing lungs, kidneys, liver, and spleen of the same embryos. This work has been confirmed by Burnet in Australia.

Research in the artificial cultivation of the poliomyelitis virus is important because it may result in supplying investigators with larger amounts of virus to study and possibly to prepare better poliomyelitis vaccines and more potent antisera. It is not unlikely that an important reason for the failure of poliomyelitis vaccines in the past is the relatively low concentration of virus (antigen) present. In vaccination against other diseases, it is well known that the number of bacteria (antigen) present in the vaccine is a very important consideration.

#### SUSCEPTIBLE EXPERIMENTAL ANIMALS

The lack of a suitable experimental animal has restricted progress in infantile paralysis research considerably. The virus is generally pathogenic only for certain species of old world monkeys and chimpanzees but not for rabbits, mice, and guinea pigs. The Asiatic rhesus monkey (*Macaca mulatta*) is the species most commonly studied, although the cynomolgus monkey and chimpanzee are being used more frequently because the latter are more susceptible to the virus and the experimental disease in them more closely approximates human poliomyelitis. Ordinarily the rhesus monkey is susceptible only when virus is inoculated directly into the central nervous system, while both the chimpanzee and cynomolgus monkey can be infected by oral and peripheral inocula-

tions as well. It is needless to point out that monkeys and chimpanzees are costly and difficult to obtain in large numbers.

A notable contribution to infantile paralysis research was made in 1939 when Armstrong of the National Institute of Health succeeded in adapting a recently isolated strain established in monkeys to the southern cotton rat (*Sigmodon hispidus hispidus*). The Lansing strain came from a fatal case of bulbar poliomyelitis in Lansing, Michigan. After establishing the Lansing strain in the cotton rat, Armstrong was then able to adapt this strain to the white mouse. The white mouse is an ideal laboratory animal from the point of view of availability in large numbers and low cost.

Since the work of Armstrong, most attempts to adapt other strains recently isolated from patients or monkey passaged strains to various species of cotton rats, field mice, and the smaller laboratory animals have failed. There have been a few reports of successful adaptation to rats, mice, and guinea pigs, but in most instances the evidence presented is not entirely conclusive. Unfortunately, certain rodents are known to suffer from spontaneous paralytic diseases so that it is often difficult to determine if paralysis is due to the inoculated poliomyelitis virus.

#### PORTAL OF ENTRY

Until recently it was generally believed on the basis of epidemiological observations and occasional isolation of the virus from nasopharyngeal washings of cases and carriers that the upper respiratory tract is the portal of entry and exit of the virus. Furthermore, studies of the experimental disease in monkeys suggested that the virus entered through the nasal mucosa and reached the central nervous system through the olfactory nerves. Infection failed to occur in the monkey if the olfactory tracts

were cut prior to instilling the virus into the nasal cavity or if zinc sulfate was applied to the olfactory mucosa. The evidence that the virus used the olfactory pathway in man, however, was not so conclusive. Histologic examination of olfactory bulbs of human cases failed to disclose any consistent marked pathologic changes that are usually seen in the monkey following intranasal inoculation. Thus far the presence of the virus has not been demonstrated in human olfactory bulbs, and disappointing results were obtained in the application of zinc sulfate to the olfactory mucosa in two poliomyelitis epidemics.

The occurrence of poliomyelitis during the summer months suggests transmission by (1) ingestion of contaminated water and food or (2) insect vectors. During the past two years there have been many reports in the literature indicating that the virus may be readily isolated from the stools of abortive cases, and healthy contacts as well as paralytic patients, and convalescents from the disease. *Cynomolgus* monkeys can be infected by the oral route, and Howe and Bodian of Johns Hopkins University recently were able to infect chimpanzees by feeding large amounts of stool from poliomyelitis patients by stomach tube. The possibility of infection through the nasal mucosa was excluded by cutting the olfactory tract before feeding.

Piszcsek and his associates studied an outbreak in a Chicago suburb last summer which revealed a striking example of spread by carriers. The source of infection was traced to three children operating a lemonade stand in the yard of their home where many children of the neighborhood played together and some of whom drank lemonade. Virus was isolated from the stools of 6 of 38 persons who were in contact with those who subsequently developed poliomyelitis. In one instance virus was isolated

from the stool of a presumably healthy person two months after his contact with poliomyelitis cases. In the summer of 1939 Paul and Trask of Yale recovered the virus in raw sewage from two localities where epidemics were in progress.

The intestinal mucosa has been considered the portal of entry of the virus by the proponents of the "ingestion theory." Sabin has isolated the virus from the wall of the ileum and colon of poliomyelitis patients. It is also possible that the virus may enter through the pharyngeal mucosa from contaminated water or food. The virus has been isolated from the pharyngeal mucosa and tonsils of fatal cases, and a significant correlation exists between cases of bulbar poliomyelitis and tonsillectomy performed during epidemics. In view of this, it may be wise to postpone elective tonsillectomy during the poliomyelitis season, or at least in the presence of an epidemic.

Epidemiologic evidence does not point to contaminated water supplies or milk as the source of infection in most outbreaks. The spotty distribution of the disease and relatively higher incidence in rural communities suggest that poliomyelitis might be insect-borne. In the past attempts to transmit the disease by various insects gave negative results. Furthermore, it was believed that the absence of the virus from the blood stream was further proof that infantile paralysis could not be transmitted by blood-sucking insects. The question of the presence of the virus in the blood stream and possible spread by blood-sucking and biting insects has been raised once more by the recent work of Sabin and Ward in which they demonstrated virus in the blood of *cynomolgus* monkeys paralyzed after oral infection with a strain of recent human origin. Last year three reports appeared announcing the isolation of poliomyelitis virus from flies (chiefly houseflies and

blowflies) trapped in the vicinity of epidemics. Virus was isolated from 12 separate batches of flies. These results suggest that possibly the virus might be carried from feces to food by flies such as occurs in typhoid fever.

#### CLINICAL ASPECTS

Contrary to the optimistic reports on the value of potassium chlorate in the treatment of poliomyelitis by various European workers, we and others have found this drug of no value in therapy. The various sulfonamide drugs tested so far have yet to prove to be of any therapeutic value. The value of human convalescent serum is still controversial, although Kramer reports protection up to 24 hours when human convalescent

serum is given to white mice following inoculation with the Lansing strain. In a series of semi-annual progress reports which we have submitted to the National Foundation for Infantile Paralysis since 1939, experimental evidence is presented which confirms clinical impressions that fatigue and chilling are predisposing etiological factors in lowering resistance to infantile paralysis, whereas mechanical trauma has no apparent effect on the incidence and severity of paralysis. These results suggest that undue fatigue and chilling should be avoided during an epidemic.

This paper was presented by Dr. Levinson substantially in its present form at the Pre-convention Group Conference on Orthopedic Nursing, Biennial Convention, Chicago, Illinois, May 16.



## NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

#### PLACEMENTS

\*Lucille Musgrove, nursing field consultant, American Red Cross, Midwestern Area, St. Louis, Mo.

Marion C. Bakken, orthopedic field nurse, State Department of Health, Boise, Idaho

\*Sarah Seybold, orthopedic nurse and physical therapist, Visiting Nurse Association, Evanston, Ill.

Bernice Brudzinski, county tuberculosis nurse,

Will County Tuberculosis Association, Joliet, Ill.

Florence E. Edner, rural staff nurse, American Red Cross, Harrisburg, Pa.

Mrs. Mabel T. Conover, staff nurse, Syphilis Control Program, Chicago Health Department, Chicago, Ill.

Elsie E. Johnson, camp nurse, Camp of United Charities, Algonquin, Ill.

Gertrude M. Haydon, camp nurse, Kechuwa Camp, Michigamme, Mich.

\*Mrs. Jean M. Renault, camp nurse, House of Three Bears, Green Lake, Wis.

Margaret E. Wittwer, camp nurse, Camp Eagle Crest, Eagle River, Wis.

#### ASSISTED PLACEMENTS

\*Grace Beers, supervisor, Sussex County Health Unit, State Board of Health, Dover, Del.

\*The N.O.P.H.N. files show that this nurse is a 1942 member.



Four Indian mothers confer with dhais



Pregnant woman in purdah travels covered

## Health Visiting in India

By SISTER ALMA JULIA LE DUC

**I**T WAS during the hot month of July in India, while Sister Stephanie was on her vacation and I was taking her place as health visitor, that I met a little Mohammedan girl named Makbul Jan. I do not know whether I shall ever meet her again but here is the story of the few hours I spent with her.

The student *dhais* or illiterate native midwives who take the course at the Health Center must have the health visitor supervise their cases during their period of training. It was late in the afternoon and I was back in the Holy Family Hospital when a Sister brought me the identification card of one of these *dhais*. She had called to take me with her on a case. I immediately grabbed my bag and joined her in the office. She was a stranger to me, a young Mohammedan girl in a pink *burkha*—a circular garment which is thrown over the head and covers the whole person. As we hailed a *tonga*, a light, two-wheeled vehicle drawn by ponies or bullocks, and got on our way she explained

a little about the case to me. Since I understand very little Punjabi, I could grasp only the essentials of what she told me. The patient, who was not registered or known at the Center, was having her first baby and was in labor.

We went in the *tonga* as far as it could take us toward our destination. I paid the *tonga-walla* three *annas* or about 15 cents and we started out on foot across the fields where there were many new houses and huts scattered in a haphazard manner over the countryside. There were no streets. I see now why the lanes and alleys in some sections of the native city are as they are. Apparently the first houses are built at random; more and more houses are joined to them as the years go by; and finally, the only spaces left in front of or between rows and groups of houses become the lanes and alleys of the crowded city.

After crossing several ditches and plowed fields and circling walls and huts, we arrived at our destination, a typical middle-class Mohammedan dwelling



with a high brick wall enclosing the courtyard. An elderly woman in the courtyard, probably the mother-in-law, was preparing the evening meal. An *anguthi*—a clay-covered, movable native stove—and several large water jars were in one corner where she was working. Two native string beds, *charpois*, were also in the center of the courtyard; and a large *hookah*, a native pipe for smoking, was between them.

We passed through onto the porch where a woman about twenty years old was sitting cross-legged with a six-day-old baby in her arms. Passing them, we went into the room where our patient was lying on the third bed near the shelves and boxes and whatnots.

Everything was beautifully neat and clean. The beds were covered with bright-colored, embroidered cloth. A shelf running along the entire back wall was filled with silver trays, glasses, china cups and saucers, and odds and ends. There were a couple of tables and chairs, and a tripod for the hurricane lantern—a strange mixture of East and West. The older woman who had followed us in placed an armchair by the patient's bed for me to sit on. They all salaamed graciously and pleasantly.

The patient sat up in bed, all smiles, and looked at me. I'm sure she had never seen anyone just like me before in her life, and she seemed thrilled at having me visit her. I smiled back at her and tried not to look too surprised. What I saw before me was a pretty Mohammedan girl. She was very young-looking, with beautiful, dark eyes which seemed to twinkle at the least provocation, and a set of teeth which pointed her smile in such a way that I thought to myself, "Any tooth paste company back home would be glad to have you for an advertisement."

But I knew I must get down to business.

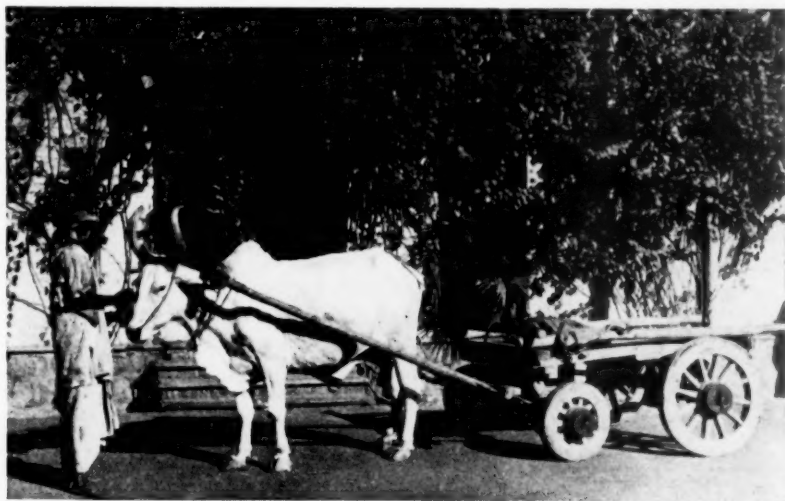
"Your name?" I asked. I can speak a little of the Urdu language.

"Makbul Jan."

"Your age? How old are you?"

"Twelve years."

I questioned that. Not that she looked any older, but it is such a surprise to get a definite answer to the question about age. Usually the answer is, "I don't know," and the mother and mother-in-law and husband all have to be questioned before the age is decided upon. But in this case they were all insistent that the answer was correct.



The tonga-walla will drive the nurse supervisor to her patient

This was my first experience with so young a patient, and for a moment I felt a little panicky. When I had obtained the information I needed for the Center report, I stopped my questioning and examined the patient. First came the abdominal palpation. The position was L.O.A., fetal heart sound very good, the patient having very definite and hard contractions. Again I was a little surprised at her unconcerned attitude and her smile. I almost doubted at first that she was in labor.

"Now tell me when you have a pain and again when it is finished," I said as I sat down again. "I want to see how close together the pains are and how long they last." I took out my watch.

She treated this as some sort of game, watching me more closely perhaps than I was watching her. "Now," she said, nodding her head as a pain started. "*Bas* (finished)," a half minute later. They were coming every three minutes.

"What time is it?" she asked me. I showed her my watch, but she just smiled and shook her head. She could not tell time. Most of these women can't. It was ten minutes past six, but I could not remember the correct way of saying it. "It is six o'clock and ten minutes more," I said. She understood.

Then she jumped out of bed and skipped out into the courtyard and returned with her *hookah*—probably her own, as there was the big one still between the two beds in the courtyard. In fact, the older woman was now puffing away on it at intervals. When I went out to hunt up the *dhai*, I saw she also was having a smoke while more or less leaving the patient in my hands. I had taken out a glove. I wanted soap and water. They both jumped to wait on me. I returned and found the patient sitting up again smoking away furiously at her *hookah*. On rectal examination I found that she was almost three fingers dilated. Then I had the *dhai* give her an enema, which I supervised. Makbul

Jan jumped out of bed to find clean pieces of rag and a towel and other things the *dhai* had asked for. I almost died when I looked around and found her standing on the bed reaching for some things on the top shelf.

"Get into bed and lie down," I insisted.

She smiled her mischievous, amused smile and obeyed—for ten minutes. The enema was a success, although the patient looked as if she thought that we were all crazy by that time. I put my hands on Makbul's abdomen. The contractions were hard. I then gave her a small dose of a sedative. As she did not make a sound, it was difficult to tell how much she was suffering. She would only hold herself tight for a few seconds when the pains must have been at their worst.

It was quite dark now in the room so someone lighted a lantern and placed it on a tripod near us. The family were now eating out in the courtyard. They asked me if I wanted something to eat. I said I did not. "Well, just a drink then?" After a little insisting, I said I would have a drink. The *dhai* placed a small table before me and a little later came in with a bowl of very sweet hot milk. On another plate was a large, round rusk. She asked if I would have anything else—fruit, curry, or whatever. I thanked her but said I had plenty, and took the rusk and drank the milk. It was very good.

I tried to induce the patient to take something to eat or drink, but in that she would not give in. She was apparently quite content to smoke her *hookah*, which she seemed to pull at more furiously as her time drew nearer. She turned the stem of the pipe toward me once.

"Will you have a smoke?" she asked politely.

"I don't smoke. Thanks." We both smiled. All of a sudden it seemed as if we had known each other a long time.

I saw that I would probably be here a

couple of hours more; it was then after eight o'clock. During the daytime we go alone on cases, but during the night we take a companion. So I wrote a note to the hospital asking for a native Sister to join me. A man in the courtyard eating with the family—probably the husband of the patient—at my request took the note.

"It is warm in here," said Makbul Jan. "Let's sit outside."

With that she jumped out of bed again, and I followed her into the courtyard. She threw herself down on one of the *charpois* there while someone placed a chair nearby for me to sit on. There was no light in the yard but an almost full moon lighted the place so that I could even watch the time easily. Everything was calm and quiet. The meal was over and the older woman was rinsing out some utensils in the corner near the water jars. The *dhai*, who had apparently eaten with the family, sat down at the family *hookah* for an after-dinner smoke. The man of the family was on his way to the hospital to get the native Sister.

Who was the man? Was he Makbul's husband? Or was he the husband of the other woman on the porch—the one with the six-day-old baby? Often two or more brothers live together with their families in one household. Or it could be that both these women were his wives, as he looked as if he could afford more than one wife. Finances seem to be the determining factor in the number of wives a man has, rather than morals, as their religion allows a man to have four. In actual practice few can afford more than one.

I looked at Makbul lying there so contentedly looking up at the moon. She seemed very well and happy. It did not seem to matter to her that she could not read or write or tell time. Her joys and sorrows were made up of other things, and just now sorrows were in the background.

An hour or two later, her baby son was born and all was over. She smiled up again with that same joyous, half-mischievous smile and, as far as I could interpret it, her smile said, "Just look at me. I'm only twelve years old and yet I have a husband, a nice home, and now a baby boy. Could anything be more perfect?"

The Sister came from the hospital and we went back to the inner room. There the mother-in-law had put away the patient's bed and had prepared one for her on the brick floor—a couple of old blankets covered with a sheet and a small pillow. There Makbul would have to stay for three, seven, or ten days. I did not ask in this case. I have asked in other cases and the answers have varied. In one Mohammedan home recently I said to the family, "Now that the baby is born, why not let the mother get back in her comfortable bed?" "Oh, it will be only for three days," was the only answer.

Not only the Mohammedans, but also the Hindus and Sikhs have the custom—though the time is usually ten days. One explanation I was given was that everything used at child birth is considered unclean, and if the patient were to stay in bed, the bed and blankets would have to be burned later. As a matter of fact, however, most of our patients no longer follow the custom. This is due perhaps to European influence in the centers such as we have at Rawalpindi.

The baby, a lovely little boy of four and one-half pounds, arrived apparently without difficulty—no tear, no hemorrhage, no complications, and not a sound from the mother! Just a smile afterwards as if to say, "Now wasn't I pretty good?"

The man of the house took Sister and me across the moon-drenched fields and ditches to Murree Road and put us on a *tonga*, paying the *tonga-walla* to take us to the hospital. I said a prayer of

(Continued on advertising page 9)

# Social Priority No. 1: Mothers and Babies

BY MARGARET W. THOMAS, R.N.

The certified nurse-midwife is one acceptable means of securing better care for mothers and babies

THE WAR has heightened the so-called midwife problem. Would that it were a midwife problem! But, it is not that alone; it is the problem of hundreds of thousands of mothers who every year get no professional care before, during, or after the birth of their babies.

Year after year, 250,000 women bearing babies—one tenth of all such mothers in the United States—are given at best only the superstitious, unclean care of midwives who have no right to call themselves such. We are negligent and thoughtless of the life and health of more mothers and babies every year than there are babies born in Norway, Sweden, Finland, and Ireland.

Today doctors and nurses are leaving large and small communities alike for active service with the armed forces or for work in the booming defense towns. Unless something is done and done promptly, many more than just the mothers and babies who were thoughtlessly neglected in peacetime will be added to the ranks of the poorly cared for or those not cared for at all, now that we are at war.

This is not a problem which can be shelved until the war is over. It lies at the very roots of national morale. The mother who knows she should have good care and is unable to obtain it is uneasy and worried. The man behind the gun or the man behind the machine looks at this war, first in terms of *his* family and *his* loved ones. It is demoralizing for any husband and father to think of his

wife and child left to the attention of untrained, unskilled, unscientific attendants, whether they are in an isolated farmhouse in the hills, in a crowded defense community, or in an institution which may have no right so far as standards are concerned to call itself a hospital.

The midwife problem has been traditionally looked upon in a negative sense, that is, solely in terms of regulation and control of granny midwives. Legislation was enacted on the assumption that the granny was a faker and a medical quack, when in reality, in most cases she was a leader in her community. Certainly no granny midwife ever entered upon her profession for the money in it. The best she could expect was a few dollars, a sack of potatoes, or a promise. It was her contribution to the Kingdom of God, and all too often she had nothing but heavenly guidance.

## LEGISLATING MIDWIFERY

In a decade or two, the effect of this controlling legislation will be to make the granny midwife as extinct as the dinosaur. From some points of view this would be a success, but at best only negative success since adequate facilities for maternal care have not at the same time been furnished. A plan to provide proper care for every mother and her baby, whether she can afford to pay for it or not, is necessary in peace and in war. This is a basic need in order to prevent ill-health and needless death. Mothers and babies are social priority number one. When Americans realize this, safe obstetric care will be provided as we now provide ships and tanks and planes.

Too many community leaders are content with obstetric care as it is, because all they ever see is the most luxurious care in the world rendered to a very few women by obstetric specialists in the best hospitals. They never see the disgraceful care or the lack of any care at all which is the lot of hundreds of thousands of American mothers.

Fortunately the leaders in maternal and child health have not ignored this situation. They have thought, planned, and acted to good effect, especially in recent years. Of course, wherever there are competent doctors and nurses, safe care can be provided. But for those mothers who live far from a doctor and hospital, or for those who cannot afford their services, this is no solution at all. All mothers will have adequate care only when communities are ready to make it available as an essential public service.

A plan has been advanced to create a new type of obstetrical attendant to replace the granny midwife—a type of attendant whose practice would be easier to control and license. Young intelligent women would be specially recruited for this work and given a short, intensive course in the management of labor. They would then be expected to work out their own salvation, getting experience from practice. This proposal is at best only a stopgap and one which creates more problems than it attempts to solve. The free-lance midwife's income is small and scattered. How to recruit large numbers of the most intelligent young Negro women without promising them any hope of regular and adequate income seems an insurmountable problem. This plan would seem to be only an attempt to find another group poor enough to exploit.

The certified nurse-midwife is a third alternative. She is a nurse trained in a school of nursing with accepted standards. She has additional public health

nursing preparation. She is a bit of an idealist who sees in the coming of new life the hope of the future and who believes that maternal care is a vitally important contribution to the community and the nation. This certified nurse-midwife is thoroughly trained by competent obstetricians in the art and science of obstetrics. She works always under medical guidance and supervision.

I had the rare opportunity during the past nine months of helping to establish a school for nurse-midwives at Tuskegee, Alabama, under the auspices of the Macon County Health Department, the United States Children's Bureau, the Julius Rosenwald Fund, Tuskegee Institute, and the Alabama Department of Public Health. On Friday, March 13, in the face of the ancient superstition, the first class was graduated with ceremonies suitable to this important occasion.

#### MATERNITY IN ONE SOUTHERN COUNTY

Macon County is typical of hundreds of other communities in this same region. Of the 26,000 people living in the county in 1941, 81 percent were Negroes. In 1930, there were 129 granny midwives, who delivered more than 80 percent of all the women delivered during that year. By 1938, the number of midwives had been reduced to 50, but they still performed 75 percent of the deliveries. The maternal mortality rate among Negroes in Macon County was 90.2 per 10,000 live births. The rate for the total population of the county was 81, which was almost double that for the United States for the same year. Between 650 and 750 deliveries take place in Macon County each year, but there are only 9 physicians to care for these women and babies. The need for a school for nurse-midwives was twofold: student nurse-midwives wanted patients to serve, and mothers were dying needlessly for lack of maternal care.



Before the school was opened, it was necessary to develop a county maternity program. Five Negro nurse-midwives, trained by the Maternity Center Association, were gradually added to the staff of the county health department. Each was assigned a district, where she carried on a generalized public health nursing service, including midwifery. A Negro obstetrician was appointed to supervise and direct the midwife service. Expectant mothers were searched out, antepartum clinics were organized throughout the county, and a home delivery service by nurse-midwives was offered to these mothers. Thus, the groundwork was laid for the opening of the school which took place on September 15, 1941.

The Macon County Health Department requested the Maternity Center Association to lend one of its experienced certified nurse-midwives to organize and direct the school for the first term. The author was selected for this very interesting and thrilling experience. Every effort was put forth to create a school with high standards of teaching and a high calibre of student. The standards were adapted from those in use at the Maternity Center Association in New York. Students were selected after a careful study of their credentials and references. They must be graduates of an accredited school of nursing, eligible for college matriculation, and must have had two years of postgraduate work. Preference is given to applicants who have had experience in obstetrical nursing, public health field work or theory, or who have a college degree.

#### COURSE OF STUDY

The course is six months in length, of which about one third is spent in theoretical instruction. Lectures, discussions, and demonstrations are conducted by the obstetrician, the nurse-midwife instructor, and other specialists. After class discussion and demonstra-

tion, the student makes home visits, first observing the work of staff members and then working under close supervision.

Students are assigned to the 20 maternity clinics held in various parts of the county each month. Here they work closely with the obstetrician and the nurse-midwife instructor, making abdominal examinations to ascertain fetal positions; taking pelvic measurements; making vaginal examinations; taking histories; making blood pressure readings; taking blood for Wassermann testing; examining urine; and doing the many other things essential for safe maternal care.

The student learns the techniques of delivery, first by watching a classroom demonstration and practicing with a manikin. Then she observes at least three deliveries. She is required to deliver 20 to 30 babies during her six months' training—always under close supervision of the obstetrician. He is available for consultation at all times and she consults him at regular intervals. Patients with abnormal conditions are delivered in the hospital on the campus of Tuskegee Institute, and the obstetrician is always present at these deliveries. Standing orders approved by the consulting staff of the state department of health and the county medical society guide the obstetrician and the nurse-midwife in the care of normal patients.

By the time the student nurse-midwife graduates, she is able, under competent obstetrical supervision, to provide safe and satisfactory care. The advantage of this close team work between the obstetrician and the nurse-midwife, from the social point of view, is that it provides adequate maternity care at a low cost, using a minimum of time of medical personnel. The nurse-midwife who is also a generalized public health nurse can fit into the county nursing program at times when she is

not occupied with duties requiring her special obstetrical training and experience.

#### THE VALUE OF THE PLAN

The nurse-midwife-obstetrician team has proved its worth. More than 7000 women have been delivered under this plan with a maternal mortality of less than 20 per 10,000 live births. While this is not a large number, the experience afforded was sufficiently broad and varied to demonstrate the value of the trained nurse-midwife as an obstetrical attendant. She has cared for mothers under difficult conditions in crowded urban tenements, in isolated farm homes, in the sparsely settled and primitive mountain dwellings of the South; she has cared for white and for Negro women—all in the lower income group.

#### MORE TRAINING CENTERS NEEDED

The facilities for training nurse-midwives are inadequate to meet the rising demand for their services. Small schools such as the one now being conducted at Tuskegee cannot entirely meet the need since the cost of training is too high per student. Other countries, notably, Sweden, the Netherlands, Norway, and Denmark, where a large proportion of all the deliveries are conducted by midwives, have central schools for midwife training. These schools are government-financed, and are closely connected with universities. Not only are they educational centers, but they also play an active role in selecting midwives for placement; both on the basis of ability and on the needs of the various communities.

Such a system might well be adopted for nurse-midwives in America.

The nurse-midwife can help bring together and make more effective the various resources in the community to protect the life and health of mothers and babies. There is a great need to spread out the highly technical and specialized services of obstetricians into the broader reaches of the community; to provide care to mothers on the basis of medical need rather than economic status; to make better use of hospital beds, of clinics and educational facilities. Up to the present time, we have never put a high enough cash value on expert obstetrical service. We have thoughtlessly wasted the services of doctors, nurses, and hospital facilities by utilizing them on a hit-or-miss basis. The time is ripe for co-ordination of these services to meet the total needs of a family when a baby is coming. We need a total plan for total health.

Never in the history of the world has social planning been so urgent. The chaos of the post-war years to come may be the most difficult and trying in the history of mankind. Only those nations—including the victors in the present struggle—that have a solid social foundation and definite social goals will weather the storm successfully. This is not the time to permit serious gaps in our social structure to widen, nor is it a time to fill in these gaps with make-shifts. The nurse-midwife teamed with the obstetrician can help supply this lack in maternity care with service of recognized value. She can thus make her contribution toward the task of creating a strong America of tomorrow.

The September issue of the magazine will be a special school and preschool number,

# Nurse's Role in Industrial Health

By ORLEN J. JOHNSON, M.D.

**T**HE ROLE of the nurse has broadened with the development of preventive industrial health. This development, slow in beginning, has been accelerated tremendously since the United States entered the war. Industrial nursing, as we are coming to know it and as it is important to the war production effort, is prevention of illness and accidents among workers, and only when that fails, treatment. In fact, this can be said about preventive industrial health as a whole. Treatment enters in only when prevention fails. It is receding in importance in relation to the broader scope.

An "Outline of Procedure for Physicians in Industry," has been published by The Council on Industrial Health of the American Medical Association.\* It embodies the general principles and functions of industrial medical service. It states:

The purpose of medicine in industry is to promote the health and physical well-being of industrial employees. These objectives should be accomplished by:

1. Prevention of disease or injury in industry by establishing proper medical supervision over industrial materials, processes, environment and workers.
2. Health conservation of workers through physical supervision and education.
3. Medical and surgical care to restore health and earning capacity as promptly as possible following industrial accident or disease.

These principles cover nursing activities, for nursing is an integral part of industrial medical service and is particularly important in developing and carrying out a preventive program. The

fundamental rules of the relationship of physician, nurse, and patient are not altered; the responsibility of each has not shifted. This code is the result of experience as to what constitutes the best practice for the good of the patient. However, the duties of each have increased. With this increase there is in fact a greater reciprocal dependence between physicians and nurses.

The practical application of preventive industrial medicine is reducing to a minimum the time lost from employment through illness, whether occupational or nonoccupational in origin. Less than 10 percent of this absenteeism is caused by occupational accidents and diseases; the rest is due to afflictions common to the general population. Noteworthy gains have been made in occupational accident and disease prevention, not only because of the legal responsibility of the employer but because there is a direct and an intangible financial loss from interrupted production. If this is true, the loss from ordinary sickness, outside of compensation costs, is nine times as great. These financial aspects are important in presenting a program to industry. One company reported recently that a proper medical service could save them \$70 per employee per year. This is the language industry understands, though many employers are interested in the humanitarian aspects as well.

## WAGE LOSS TO WORKER IS SERIOUS

Even more important is the loss in wages to the worker and his family. Management has learned to include these losses in the cost of production, which is reflected in the price of the product.

\**The Journal of the American Medical Association*, March 14, 1942, page 895.

Unfortunately, the wage earner is unable to make such an adjustment during sickness and the compensation he receives from occupational injury is a poor substitute for good health and a full pay envelope. As a result, a vicious cycle is established. Sickness stops his income, which lowers his family's standard of living. This not only lowers his efficiency as a worker but is manifested in the well-being of the entire family. It is axiomatic that the economic state has a direct bearing on general health.

The implication is obvious. Preventive industrial health if properly carried out will help improve the whole social structure.

Numerous studies in industry have shown that 12 to 15 percent of the workers cause 55 to 60 percent of the lost time due to sickness. Attention to this sickness-prone group will show the greatest return. A program directed toward them may consist of consultation with the individual with the object of determining, if possible, the cause of his repeated illness. In some instances, it is poor health habits or nutrition; in others, economic difficulties, marital complications, or family sickness. A preoccupied worker is inefficient and unsafe. If it becomes apparent that there is need for a physical examination he must of necessity be referred to a physician. Here is where it is particularly advantageous to have a doctor in the plant, even on a part-time basis, to make the industrial medical department of diagnostic aid. In all instances of non-occupational conditions, the patient should be referred to a physician of his choice for treatment. This type of work requires the keeping of absentee records, for it is from the study of such data that these individuals are recognized.

Of the utmost assistance is keen observation by nurses and foremen. When a patient comes in for treatment it is within the province of the nurse's duty to recognize whether or not he is healthy.

If he does not appear well, tactful and intelligent questioning may indicate the need for medical attention. Many more patients are seen by nurses than by doctors in the plant medical department—which places the nurses in a much better position for case-finding. If a physician is not available in a small plant, even more depends on the nurse. Yet by no stretch of the imagination is it the responsibility of the nurse to render advice or make decisions that lie beyond the limits for which her training has equipped her. Such practices will bring more justified criticism or difficulty than if she is overly dependent on medical assistance. Usually a suitable arrangement can be made with the physician rendering emergency service, with the hope that in time the management will see the wisdom of requiring the physician's attendance in the department for specified periods.

Persistence is required to educate foremen to the point where they will realize the amount of good they can do by sending to the medical department workers who seem to be losing their efficiency or who do not appear to be well. In their constant daily contacts, supervisors can learn to recognize the unwell person long before that individual seeks medical aid on his own initiative.

#### ADEQUATE SUPERVISION NECESSARY

Ideally, industrial health requires putting into effect in every plant adequate medical and nursing supervision satisfactory to those who receive and those who supply the service. Nursing service is very frequently the first or the only attention given within an industry, particularly in small plants. Consequently, it can be instrumental in bringing about a more complete preventive medical program.

Recently in some areas, small plants have purchased part-time nursing service from private public health nursing agencies. In principle, the plans appear

sound but they have not been utilized to the extent anticipated. Organizations contemplating such a service would do well as a preliminary step to acquaint other interested agencies with the objectives and details of the plan—the most important of these groups being the local medical society, industrial nurses, and manufacturers' groups. In this way more active support will be received.

A definite decision has not been reached as to the best plan for service to small plants, which present the most difficult problem because of numerical superiority and size. Studies being made will help evaluate the problem and aid materially in formulating a satisfactory method of rendering this service. It has become the practice in Connecticut to recommend the employment of a full-time nurse in plants of 150 employees or more and reports indicate that some plants are doing so. This is of course better than part-time service. But, in order to make such an arrangement permanent, its value will have to be proved by a well rounded program. This can be done by a nurse with energy and knowledge of health promotion.

#### PLAN FOR CORRECTION ESSENTIAL

Individual health consultation, case-finding, and keeping of records have been mentioned, but they will be of little avail if they are not followed to successful completion. Once an unsatisfactory condition has been identified, steps must be taken which will assure correction. This requires a close working arrangement with the medical profession for remedial work, and determination of the type of employment compatible with the patient's physical condition. A properly executed plan will grow by its own merit and contribute to the welfare of the working force and the extension of industrial health. There is and should be the closest possible working relationship between nurses and doctors in industry as elsewhere.

A general health education program should be directed toward the entire working force and particularly toward those who do not come to the medical department for assistance. Talks, pamphlets, and payroll inserts have been used efficaciously. Regardless of the methods used, they should be so planned that the benefits will be felt in the homes of the employees.

Nursing service is an important component of preventive industrial health. A nurse in industry with a clear concept of the objectives of the program is in a position of trust whereby she can influence the health and welfare of a larger group of individuals than any other branch of the nursing profession. The rapid change in the conception of industrial nursing, due to the emergency of increased production, places an added responsibility on nursing organizations, for one of their fundamental purposes is aiding their members to keep abreast of advances in the profession. Usually basic nursing education has not for the most part included or sufficiently emphasized prevention, particularly as related to industrial health, and this important aspect of nursing should be given a place in undergraduate preparation. Industrial relations and procedures should be taught to nurses who have been working in official and nonofficial public health nursing agencies. Nurses who are working in industry should be given the working armamentarium of health education and prevention as applied to its workers.

Since nursing is fundamental in industrial health, its organizations and individuals can make valuable contributions toward the successful completion of the war and the future health of the nation by using their influence to bring about the extension and the improvement of industrial health practices.

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Presented before the N.O.P.H.N. Preconvention Conference on Industrial Nursing, Biennial Convention, Chicago, Illinois, May 16, 1942.



# A Study of Negro Nursing

BY PAUL B. CORNELLY, M.D., DR.P.H.

**The report of a study of the employment of Negro nurses by visiting nurse associations in the United States during the period 1930-1939**

A STUDY of the present trends in public health activities in relation to the Negro in the United States during the decade of 1930-1939 was made under the auspices of the Julius Rosenwald Fund in 1940 through a grant to Howard University, College of Medicine, Washington, D.C. It was deemed advisable and necessary to include in this investigation the visiting nurse societies because this group of voluntary health organizations devoted primarily to service has played an important role in the health progress of the Negro. Surprisingly enough, during this period of ten years apparently only one investigation\*, in this field has been published and therefore the present report should be of value in providing information as to present activities, in stimulating further research, and in serving as a base line for the evaluation of future progress.

Letters and questionnaires were sent to 75 organizations selected from a list which was furnished by the National Organization for Public Health Nursing. The questionnaires requested information as to Negro personnel employed; services given, separated according to race; and personal reactions to certain questions. Of the 75 schedules, 48 were returned. Nine were not included in the analysis either because of incompleteness in returns or tardiness in replying. This

left 39, or about half, for study. As a whole, the answers were complete with the exception of those giving information as to services rendered according to race. In most instances it was stated that such separation was not available and therefore it is impossible to evaluate the progress which has taken place in this sphere during the past decade. Of the 39 organizations whose replies were summarized, 27 were located in 24 cities in the North and 12 in an equal number of cities in the South. Chicago, with four organizations within its boundaries, had the largest number.

## EXPENDITURES FOR NEGRO WORK

The 39 organizations served a population of sixteen and one-half million individuals of whom a million and a half were Negroes. Twenty-three northern organizations spent \$2,799,147 or about 22.4 cents per capita for Negro work in 1930 while 11 southern associations spent \$783,386 or 21 cents per individual. By 1939, this had increased to 23.2 cents for the North, but still remained about the same, 20.9 cents for the South. On the basis of these data and knowing that the population had probably increased in both of these areas during this period, it is fair to assume that there is a decrease in the money spent by these organizations for Negro work today as compared with that of ten years ago, and this trend has been more marked in the South than in the North.

It is regrettable that a majority of the

\*Bowman, Anne H. *The Negro Nurse in Urban Visiting Nurse Service*. Visiting Nurse Association of Detroit, 1940.

organizations did not report on the amount of their budget spent for Negro work. Only eight of the 39 organizations did so. Without a single exception all of these eight spent per capita amounts for Negroes which were proportionately from two to four times that spent by the associations for their activities as a whole. This was true in both the southern and northern visiting nurse associations. A budget decline is noted for the year 1935 but by 1939, five of the eight organizations were spending more for their Negro programs than in the year 1930. Although the per capita expenditure is possibly not the best measure of progress in this instance, it shows that these organizations apparently have definitely given attention to Negro health and have bettered these opportunities during this ten-year period.

#### EMPLOYMENT OF NEGRO NURSES

The trend in employment of Negro nurses in organizations such as these is of interest because it signifies enlarged opportunities for work for trained individuals of this race.

Opportunities for Negroes in this field have not markedly increased during the period of 1930-1939. Of 34 organizations which reported for 1930, 15 employed full-time Negro nurses, or an average of four for each northern society and seven for each southern one. For 1939, of 37 reporting, 20 organizations stated that they employed 93 Negro nurses. Thus only five additional societies had joined the ranks of organizations which employed Negro nurses during this decade. It is also of interest that the average number of Negro nurses employed per association decreased from 5.0 to 4.7 while in this same interval, the number of white nurses had increased from 1140 in 33 associations to 1489 in 37. The average number of white nurses per association also rose from 34.5 to 40.2.

In 1930, twenty organizations report-

ed the employment of 91 full-time Negro nurses; in 1939, twenty-two reported 103 Negro nurses. These 103 nurses were to be found among a total Negro population of 1,422,719 according to the 1930 census.

Certain other interesting facts are also observed. For instance, by supplementing the data secured in this study with other published data, a total of 37 nursing associations are found to be employing Negro nurses. Furthermore it is seen that the Chicago Visiting Nurse Association was the first, in 1905, to employ a Negro nurse, followed by the Henry Street Visiting Nurse Service in 1906. The most recent one to do so is the Visiting Nurse Association of Milwaukee which in 1938 employed a part-time Negro nurse. Of significance also is the fact that during the 10 years only six of these organizations offered 20 fellowships for further study to their Negro nurses, and of these, 13 were awarded by the Chicago Visiting Nurse Association. Thus approximately two fellowships per year have been awarded by 24 organizations reporting. It is hoped that these associations are carrying on a continuous in-training program of staff education for all of their personnel and particularly for their Negro nurses, since all too often they have had the handicap of poor undergraduate education.

Only nine of the 39 organizations provided information concerning types of nursing visits according to race. With the exception of visits for maternal care there is not very much difference between Negro and white groups in the percent of visits in each classification type. It appears that many more visits are made to Negroes for antepartum and postpartum care than to whites. This, however, is merely suggestive in view of the small size of the sample.

The following questions were asked in order to obtain the personal opinion of the directors of the organizations that participated in the study: 1. What do

you consider the five most important health problems in the Negro population in your community? 2. What future plans for Negro health programs are being formulated for your organization? 3. What have been the three most important obstacles in developing Negro health programs?

#### IMPORTANT NEGRO HEALTH PROBLEMS

Although certain specific disease conditions are named as the most important health problems in the Negro population, of more significance is the fact that housing, nutrition, and lack of medical facilities and care are given prominent places on the list. Although the importance of these items is often assumed, health departments and other health organizations all too often overlook the gravity of these deficiencies in their health programs. Certainly more attention should be given to nutrition and housing—significant contributors to disease—in the development of future health plans for Negroes.

The second question is of interest since it suggests some of the plans which are being projected for the improvement of the health of the Negro. Two facts are of pertinence here. Surprisingly enough, almost 50 percent of the organizations are not planning any programs specifically designed for Negroes. And second, although nutrition was mentioned as the fourth important health problem among Negroes not one of these associations is formulating any program designed to meet this deficiency.

Analysis of the answers to question three is of great value since it suggests to public health workers many of the important obstacles which these organizations have had to meet in developing health programs for Negroes. These should be of value when considering or evaluating health plans for Negroes; for the removal or amelioration of any of

these handicaps in part or as a whole will mean greater success for whatever plan is being projected. All of the obstacles mentioned are of importance; however, a word of caution must be said about one of them. A hindrance which has a high place on the list is failure of Negroes to cooperate with the health agencies in their communities. One wonders whether the failure is due to the Negro's ignorance of facilities and services available to him and the procedure whereby these may be obtained, or whether the personnel of many of these agencies has failed in its job of establishing the proper rapprochement with its Negro clientele and thus alienated their good will. Both of these are plausible causes for the existence of this situation. It appears that the first could be solved by more education and the second by inquiring into the attitudes of the staff members of these organizations, particularly those of white nurses towards their Negro patients. This is an argument in favor of the employment of Negro nurses in agencies with large Negro loads since they are better able to understand the mores and motivations of their own people and therefore do not have these psychological barriers to hurdle. It is the progressive public health opinion of the day that Negro personnel are best able to manage Negro patients. This has been well stated by Dr. Parran, Surgeon General of the United States Public Health Service: "... there emerged clearly the fact that the well-qualified Negro nurse and physician are much more successful in caring for their own people than are the well-qualified and well-intentioned white nurse and physician. . . . That's why we need more good ones helping on the public health job, and we need them now."\*

\*Parran, Thomas. "No Defense for Any of Us." *Survey Graphic*, April 1938, page 201.

# The Negro Public Health Nurse

Report of the N.O.P.H.N. Conference  
on the Education and Employment  
of the Negro Public Health Nurse

**T**O WHAT extent are qualified Negro public health nurses finding employment? How can employment opportunities be enlarged? Can the education of the Negro nurse for public health nursing be bettered in relation to employment opportunities? These three questions and their ramifications were considered at the N.O.P.H.N. Conference on the Education and Employment of the Negro Public Health Nurse—the first of its kind—held in Chicago on May 22, 1942. More than one hundred public health administrators, educators, and others close to the problem attended.

In the talk that opened the conference, Mrs. Estelle Massey Riddle, superintendent of nurses of the Homer G. Phillips Hospital School of Nursing in St. Louis, Missouri, pointed out that it would be short-sighted indeed on the part of any planning body to ignore the contribution of any group of nurses when nurses are so badly needed. Injecting a public health approach into the basic education of the Negro nurse is important, as is practice in fields similar to those in which they are most likely to work later in the deep South. Educational opportunities in public health nursing exist for Negro nurses in the larger universities and colleges in the East and in some parts of the West.

The Negro nurse must have educational opportunities commensurate with the opportunities for employment offered in her community. Because of conditions of work in southern communities—where the greatest health needs still exist among the Negro people—the well-qualified public health nurse often does not return there to work.

In only four cities in the United States have Negro public health nurses been able to advance to supervisory positions in public health nursing. More opportunities for advancement seem to exist in institutional nursing.

That the Negro nurse must understand clearly the social attitudes affecting her as a member of a minority group in a democracy—the largest minority group in the country—and the conditions of work rising out of these attitudes, was brought out by Mrs. Riddle. As to local social patterns of attitude and behavior in regard to Negroes, it may be said that indifference to them in the North may be just as inhibiting as the open discrimination of the South.

Mrs. Riddle expressed herself as believing that along with the rising sentiment for the employment of Negro public health nurses must be developed more active support of this practice as a general policy by employers of nurses.

## INCREASING EMPLOYMENT

Figures indicating increased employment of Negro public health nurses were cited by Mrs. Mabel K. Staupers, executive secretary of the National Association of Colored Graduate Nurses. According to counts made by the N.O.P.H.N. and the U. S. Public Health Service, there has been an increase from 549 Negro public health nurses employed in 1931 to 797 in 1940—a total increase of 248 or 45 percent. Over three fourths of this took place between 1938 and 1940, 193 additional Negro public health nurses being employed during that time, due largely to provisions of the Social Security Act which resulted in a general rise in employment of public health nurses. In the year 1941, 17 public health nursing associations were known to employ Negro pub-

lic health nurses and 3 others have since reported adding Negro public health nurses to their staffs. One of the facts brought out by Mrs. Staupers was that differences still exist in many agencies between salaries paid white and Negro nurses for similar work, although some improvement in this situation is noted here and there. Also, more thought needs to be given to the question of Negro public health nurses serving white families, just as white nurses now serve Negro families.

To employ Negro nurses who are not well qualified for public health nursing was pointed out as an injustice to the nurses themselves as well as to the agencies employing them and the families they serve.

Agency policies and practices relating to employment of Negro public health nurses were reviewed by Dr. Hugh R. Leavell, director of health, Louisville and Jefferson County Department of Public Health, Louisville, Ky.; Theodosia W. Flud, assistant consultant nurse in the State Board of Health of North Carolina; Katharine Faville, director of the Henry Street Visiting Nurse Service of New York City; and Dr. Burton F. Austin, state health officer, Alabama Department of Public Health.

Dr. Leavell reported an increase in employment in the Louisville Health Department from 2 Negro public health nurses in 1934 to 13 in 1942. The ratio of Negro public health nurses to Negro population was said to be 1 to 4100, whereas the ratio of all public health nurses employed by the Department to total population is about 1 to 6500. In his Department, the salary range is the same for Negro as for white public health nurses. The first Louisville Negro health center, recently established in a government housing project, is thought to have accomplished more toward the improvement of Negro public health services than any other single event or

factor. Since Negro physicians in Louisville are not admitted to general hospital clinics, a diagnostic and treatment service has been included in the services of this health center, through the medical school of the university.

According to Miss Flud's report, qualification requirements for Negro and white public health nurses are the same in the North Carolina Board of Health, and stipends for further education are available for both groups. However, both the initial salary and education stipend are lower for Negro than for white nurses.

Between the years 1935 and 1942 the number of counties in North Carolina where Negro public health nurses are employed increased from 5 to 25, and the number of nurses from 20 to 50. It was pointed out that Negro nurses in North Carolina receive their preparation in small hospitals of the South and this handicaps them greatly in regard to subsequent admission to programs of study in public health nursing.

Miss Faville stated that the Henry Street Visiting Nurse Service makes the same requirements for appointment of Negro as of white nurses, and the same quality of service is expected. Negro nurses have been employed by this V.N.S. since the early nineteen hundreds. An advisory committee has recently been formed to review the organization's personnel practices and opportunities for employment of more Negro public health nurses.

#### NEED FOR BASIC TRAINING

Dr. Austin reported that the ratio of Negro public health nurses to Negro population in Alabama is about the same as that of white nurses to white population—approximately 1 to 20,000. A total of 50 Negro nurses now hold public health nursing positions in the state, 2 being employed from Farm Security Administration funds and 1 by the Visiting Nursing Association of Birming-



ham. Lack of proper basic nursing education, excessive case loads, and large areas were noted as the chief factors that prevented Negro public health nurses from doing their best work. The development of a Negro nurse-midwife program in Macon County, in co-operation with the Julius Rosenwald Fund and the U. S. Children's Bureau, and the establishment of a school for Negro nurse-midwives at Tuskegee Institute, were mentioned as significant developments.

Alabama has no school of nursing for Negroes that meets the minimum requirements for public health nurses at present recommended. Because of the war, nurses are not now released for further nursing education in other schools. In regard to salaries, Dr. Austin stated that because of lower living costs for Negro nurses, salaries are also lower than those paid white public health nurses in the same agency. Efforts are being made to improve remuneration rates as well as qualifications for Negro public health nurses.

Mary J. Dunn, nursing education consultant of the U. S. Public Health Service, mentioned the fact that several Negro schools of nursing had applied for federal aid<sup>1</sup> for the training of additional nurses. The list includes: Freedmen's Hospital School of Nursing, Washington, D. C.; Homer G. Phillips Hospital School of Nursing in St. Louis; John A. Andrew Memorial Hospital School of Nursing at Tuskegee Institute; Meharry Medical College School of Nursing, Nashville; Saint Philip Hospital School of Nursing at the Medical College of Virginia; University Hospital School of Nursing (Lamar School of Nursing) in Augusta, Georgia; Lincoln School for Nurses, New York City. Federal aid has also been granted Dillard University for a program for nurse-midwives.

In regard to the number of Negro

nurses located through the National Survey of Registered Nurses, Miss Dunn stated that only 3397 schedules were returned of the 9000 sent to Negro nurses. Of these, 73 percent indicated that the nurse was in active service and 27 percent that she was inactive. Eight Negro public health nurses have been appointed by the U. S. Public Health Service to extra-cantonment and defense industry areas. The number of Negro nurses in five army units has increased—the actual number not published because of Army regulations. The Farm Security Administration recently employed 18 Negro nurses.

#### NURSE MIDWIFE FIELD OPEN

Dr. M. O. Bousfield, director for Negro health of the Julius Rosenwald Fund, summarized the discussion, reviewing the situation in regard to both basic and public health nursing education for Negro nurses, and the opportunities that are opening up for them in the field of nurse-midwifery. Greater opportunities in nursing education for Negro women, as for others, he pointed out, depend on funds for more and better educational institutions.

The evidence presented at this first N.O.P.H.N. Conference on the Education and Employment of the Negro Public Health Nurse showed that some gains have been made in the employment of Negro nurses in public health nursing positions, and that their educational opportunities are gradually increasing. It showed on the other hand, that a great deal remains to be done toward improving the basic education of the Negro nurse to enable her to be eligible for and benefit from programs of study in public health nursing. A great deal also remains to be done in overcoming discriminatory practices in employment of Negro nurses in public health agencies.

It was voted by the conference to form a council in the N.O.P.H.N. which will continue to study these problems.

<sup>1</sup>Public Law 146—77th Congress.

# State Salaries in Public Health Nursing

By DOROTHY E. WIESNER AND MARGARET M. MURPHY

**A**N INQUIRY was made in the spring of 1942 about positions and salaries of public health nurses employed by state departments of health. This was in connection with the Yearly Review made to find facts and policies in public health nursing agencies, both official and nonofficial.

The inquiry brought returns from all but 6 states. The 42 states show that 2501 public health nurses were paid entirely by state departments of health, and an additional 430 were paid partially by the state departments.

Of the 2501 nurses paid entirely by the state departments of health, 1107 were listed as assigned to local duty on January 1, 1942. Of the 42 states, 28 indicated that some of the nurses on their payrolls were thus assigned.

The number of nurses employed by the 42 state health departments varied from 2 to 275. In each of 9 among the 42, more than 100 nurses were on the payroll in January 1942. All four of the west south central states were among these 9—Arkansas, Louisiana, Oklahoma, and Texas. Texas employed 275 nurses. At the other end of this listing, according to number of state public health nurses, are Arizona and Nevada, employing only 2 each. In Nevada, however, there are 13 nurses assigned by the state department to counties or districts which contribute part of the nurses' salaries. Table I shows the number employed in state health departments according to census areas.

Of the 2501 nurses employed by the 42 state departments, 56 were directors or assistant directors. Ten states employed a total of 15 assistant directors. There were 13 educational directors

employed by 11 states. Five states reported 21 consultants. There were 95 specialized supervisors. Generalized supervisors numbered 133, and supervisors of field nurses, 161. Among the total 2501 nurses, there were 2022 field nurses, of whom 265 were specialized.

Among the specialized supervisors, maternity and child health work was the most frequently mentioned, there being 34 such specialists. Orthopedic supervisors, of whom there were 24, were second in number. Venereal disease supervisors numbered 11; tuberculosis, 4; midwifery, 4; industrial hygiene, 2; and communicable disease, 2. Among the more unusual fields of specialized supervision were dental hygiene, heart disease, cancer, and trachoma.

The specialties of the 265 specialized field nurses showed different emphases. A total of 106 field nurses were engaged in venereal disease work, of whom 64 were employed by the Texas State Health Department. The other venereal disease nurses were in 9 states. In maternity and child health, there were 55 specialized field nurses, of whom 34 were employed by the New Jersey State Health Department, the others being employed in 4 states. There were 48 orthopedic field nurses, 15 in communicable disease work, and 14 in tuberculosis. Unusual specialties included hookworm, malaria, and trachoma.

The monthly salaries as of January 1, 1942, of the directors varied from over \$350 to \$150. Table II shows the salary ranges for the different kinds of positions. The two states in which the director received more than \$350 employed many public health nurses—one, 135 and the other, 58. The lowest salary

TABLE I  
STATE HEALTH DEPARTMENTS ACCORDING TO NUMBER OF PUBLIC HEALTH NURSES  
PAID ENTIRELY BY THESE DEPARTMENTS

Census areas	Total state depart- ments	By number of nurses entirely on state department of health payrolls								No. 1942 data
		100 and over	50-99	25-49	15-24	10-14	5-9	2-4	1	
Total state departments	48	9	6	14	5	2	4	2	—	6
New England	6	—	—	3	3	—	—	—	—	—
Middle Atlantic	3	2	1	—	—	—	—	—	—	—
East north central	5	1	1	2	—	—	1	—	—	—
West north central	7	—	1	2	1	1	2	—	—	—
South Atlantic	8	1	2	2	—	—	1	—	—	2
East south central	4	1	—	—	1	—	—	—	—	2
West south central	4	4	—	—	—	—	—	—	—	—
Mountain	8	—	—	4	—	1	—	2	—	1
Pacific	3	—	1	1	—	—	—	—	—	1

of a director, \$150, was paid in one of the west north central state health departments which employed only 6 nurses.

Educational directors were employed in 11 states. In one state employing 185 nurses, there were 3 educational directors. Eight of the 13 educational directors were paid between \$200 and \$225 a month—the highest, \$260 a month, and the lowest, only \$185.

The median salary for the 69 directors, assistant directors, and educational directors was \$237. Of the 8 paid less than \$200, 3 were in small departments of less than 10 nurses, 2 in departments of 25 to 49, and the other 3 in departments of 50 to 99 nurses.

The monthly salaries of the 21 consultants varied from \$150 to \$231. Possibly some of those classified as specialized supervisors in these tabulations are called consultants in their states. There was no category for "consultants" on the form sent out by the N.O.P.H.N. but a number of states wrote this term upon the form when they returned it.

The median salary among the 133 generalized supervisors was \$179 a month. Nine, all of them in the same state, were paid more than \$250. Nine others were paid more than \$225, these 9 being in 4 states—Illinois, Michigan,

New York, and Texas. Low salaries for generalized supervisors, below \$160 a month, were paid in 6 states, scattered throughout the country. One of these paid \$125 a month was a Negro supervisor, and one a supervisor of records.

The median salary of the 161 supervisors of field nurses was about \$10 less a month than that of the generalized supervisors, \$168 as compared with the \$179 for the generalized supervisors. Twenty-four of the 42 states participating in this analysis of positions and salaries employed "supervisors of field nurses," 6 of them employing 10 or more such supervisors. The maximum salary paid such workers was \$220. Only 23 of the 161 supervisors of field nurses, 14 percent, were paid more than \$200, as compared with 51 of the 133 generalized supervisors, 38 percent. The 4 states paying more than \$200 to their supervisors of field nurses were Florida, Illinois, New York, and Texas.

Only 95 specialized supervisors were reported by the 42 states, of whom about one third were in the field of maternity and child health. The median salary of the 95 specialized supervisors was \$189 a month, as compared with the median salary, \$179, of the generalized supervisors. Moreover, the range of salaries among the specialized su-

pervisors was much wider than among either the generalized supervisors or among the supervisors of field nurses. Ten of the specialized supervisors earned more than \$250 a month, the highest rate being \$275. Six of the 10 were in the field of maternity and child health. One was in cancer, one in cardiac, one in orthopedic work, and one in social hygiene. There were 2 nurses listed as special supervisors who received less than \$140 a month. One of these was a special supervisor for pediatrics, and the other for tuberculosis.

Seventy percent of the total 2501 public health nurses employed by the 42 state health departments were generalized field nurses. Their monthly salaries ranged from \$75 to \$210. Only 16 generalized field nurses were paid

less than \$100 a month, and 259 were paid more than \$150 a month. The median monthly salary for these generalized field nurses in 42 states was \$126.

The specialized field nurses numbered 265. The median monthly salary among them was \$130. The range was not so wide as among the generalized field nurses, the highest salary being \$190 paid in California to one specialized field nurse for epidemiological work, and to another for orthopedic work, and the lowest being \$90 paid to a nurse doing venereal disease clinic work.

#### SUMMARY

The salary figures available for this review are as of January 1, 1942. Since then a number of states have redefined

(Continued on advertising page 9)

TABLE II  
MONTHLY SALARY RANGES OF PUBLIC HEALTH NURSES PAID BY 42 STATE  
DEPARTMENTS OF HEALTH, JANUARY 1942

Monthly salary ranges	By position on public health nursing staff						
	Directors, assistant directors & educa- tional directors	Consult- ants	General- ized super- visors	Super- visors of field nurses	Special- ized super- visors	Field nurses general- ized	Field nurses special- ized
Number of nurses en- tirely on state depart- ment of health payroll	69	21	133	161	95	1757	265
\$350.00 and over	2	—	—	—	—	—	—
300.00-349.99	4	—	—	—	—	—	—
275.00-299.99	5	—	—	—	1	—	—
250.00-274.99	16	—	9	—	9	—	—
225.00-249.99	13	1	9	—	4	—	—
200.00-224.99	21	4	33	23	23	1	—
190.00-199.99	—	4	3	—	8	1	2
180.00-189.99	5	1	7	17	9	6	3
170.00-179.99	1	8	43	25	18	41	21
160.00-169.99	—	2	19	31	11	46	18
150.00-159.99	2	1	4	43	8	164	60
140.00-149.99	—	—	1	2	—	57	13
130.00-139.99	—	—	—	3	1	207	10
120.00-129.99	—	—	1	1	—	724	131
110.00-119.99	—	—	—	1	—	257	1
100.00-109.99	—	—	—	—	1	117	3
90.00- 99.99	—	—	—	—	—	8	3
80.00- 89.99	—	—	—	—	—	2	—
70.00- 79.99	—	—	—	—	—	6	—
Not stated	—	—	4	15	2	120	—

# New Ways of Teaching Health in Nursing

By DOROTHY RUSBY, R.N.

**W**HAT has the community public health nursing agency to offer in the basic preparation of the nurse? Before answering this question we must decide what we mean by basic preparation. If emphasis is given to the word "basic," then we must mean those experiences which are essential for *all* students to have.

Even though practice lags behind the ideal, we can surely assume that we want every student to learn to nurse the whole patient. This presupposes an understanding of the patient's home and family life and the social factors influencing it. It follows then that the public health nursing agency with its emphasis upon family health can make a contribution toward this objective for student nurses.

However, deciding just what this preparation will include and how it can be provided is the part of this problem which needs further consideration. Public health nursing services of the caliber desirable for a student education program have been too few to meet the demand of the many students from the many schools of nursing. For years community agencies have given an intensive program to a mere handful of the student group—frequently those who were already headed for public health nursing—but have done nothing at all for the rest of the students, many of whom will be teachers of the next generation of nurses.

Experimentation which the Henry Street Visiting Nurse Service has done in the past four or five years to find a realistic way to help *all* undergraduate students in its area by no means negates our appreciation of the value of a larger field experience for every student.

Perhaps someday there will be enough

public health nursing in all communities of such high standard that it can be used for learning experiences. Perhaps in the meantime enough faculty members, head nurses, and hospital staff nurses will have had a glimpse into the community to make them community-minded in all nursing practice and teaching, and the student will be more ready to shift easily from hospital to home. For the present, we at Henry Street believe we are making a greater contribution toward that end by some of the experimental methods we are trying than we did under the old pattern. We welcome a watchful eye and plenty of discussion.

Briefly our experimentation has included three different arrangements: (1) an affiliation for the students themselves (2) field experience for faculty members in schools of nursing (3) placement of part-time public health instructors within the schools.

## NEW AFFILIATION PLAN

For the past year senior students from seven schools have had a two-weeks' affiliation with the organization, so that they can watch a skillful public health nurse at work. The school pays the field agency \$10 a student for this experience.

We are not trying to teach these students to be public health nurses. We are rather giving them an opportunity to learn what part the home and community play in the care of sickness and in health promotion. To this end each student is assigned to a senior nurse and accompanies her in all activities, including visits to homes, physicians' offices, social agencies, and the like. An extra apron and hand-washing equipment are carried for the student, and in a day or two she is encouraged to participate in



giving care. She sometimes completes the care and packs the bag while the senior nurse writes her record, or she may begin the record while the senior nurse completes the care. While traveling to and from homes, the senior adviser is constantly interpreting the observations and telling the student about the plans for the families visited. Participation in the home visit is not restricted to bedside care only, for the interested and alert student joins in the conversation. Thus she soon feels her part in the work, and usually in telling of visits refers to what "we did" in the home rather than what "Miss Senior" did.

The question may be asked: How do the families respond to a second nurse? In most cases the senior nurses feel that it makes little difference, and quite frequently patients inquire longingly for the student on the first day the nurse goes alone. And who doesn't feel a certain amount of satisfaction in having the services of two nurses rather than one?

Three case conferences are held with each group of students. Here family needs are analyzed, programs and services of other community agencies explained, and opportunities to reduce illness exemplified through specific situations. In these conferences, the discussions are not limited to home situations alone, but the student is carried back to the hospital wards and outpatient department in an effort to help her realize more vividly that people everywhere are confronted by similar motives and fears, and may be helped by an understanding and sympathetic attitude. A few sentences written by students themselves will show the meaning of the experience to them:

As a result of this experience a whole new outlook is presented, and one who formerly was just another patient becomes a human being vitally concerned with a small world of which he is the center.

I learned how important it is to inquire into

the health of each member of the family and by doing so prevent further sickness.

Similar facts can be derived from books, lectures, and the like, but seeing all this in true life creates an almost unforgettable experience.

I have never realized until the present how little I really know, and how much I have to learn.

It is amazing how people with a little encouragement will help themselves.

I have always known about the various agencies to which people can apply but this is the first time I've seen them function, and for the first time I realize what a great amount of good they are doing.

School faculty members say, "The student returns to the school with a new and more realistic interest in her patient." Watching a skilled public health nurse work with her families gives the student a better understanding of factors in the home which add to or hamper healthful living.

However, it would be folly to presume that in two short weeks the nurse can receive the necessary knowledge and skill to enable her to make independently fruitful application in the busy hospital situation. She needs help in recognizing the opportunities similar to but less spectacular than those found in the homes. For example: When a young mother in the outpatient department asks to have her dressing changed as quickly as possible because she had to leave the baby sick with measles at home alone, will the student reprove the mother? Or will she recall the homes she has visited, help to get her patient through early, and inquire about the baby's medical and nursing care? If the graduate nurse, standing by, has also become acquainted with the patients in their home and community environment, and therefore appreciates how responsive people are to help, she will at this point enter the conversation and assist the young student in her efforts.

**EXPERIENCE FOR FACULTY MEMBERS**

But how many head nurses and ward instructors have themselves had this field experience? A special program has been arranged at Henry Street for the faculty group who seek an experience comparable to that which their students have received. These nurses spend approximately one month's time with the field agency. They are assigned to district offices, observe with a senior nurse, and also carry a few cases alone. They are given opportunity to visit community agencies. Frequent conferences to discuss their experiences are held.

The workshop method is utilized for this group. Instead of learning public health nursing, their objective is to learn their own job better with our field as a laboratory. In this way they relate the new knowledge gained to their own specific hospital situations, and during their affiliation develop in detail some practical method which will show how they may enrich their teaching plans. For example: The ward instructor from the medical service improves her teaching outlines by practical consideration of the problem of preparing her diabetic patient for discharge. She knows that many of her patients return to furnished rooms where facilities for soaking feet are difficult to find, and that preparation of food for one person in a community kitchen needs different consideration from preparation of food by the patient who runs her own house. She gives practical suggestions to meet these problems. If her hospital work includes such problems as care of the aged, or how the nurse in the hospital can help to reduce the number of readmissions, or follow-up service for babies following operation for cleft palate, then *these* are problems she selects to study in her field experience.

Furnishing the school of nursing with a part-time instructor from the visiting nurse service is another method which we have tried. Not all schools are as yet

able to pay the salary of a qualified full-time public health nursing instructor. We believe that part time of a well equipped worker is more valuable than full time of an inexperienced person. Therefore, we agreed to sell the hospital, at actual cost, one or two days' time of a supervisor each week. She comes to the hospital with an intimate knowledge of the community, its many resources, and its family life, and is equipped to help those within the institution see their patients as individuals coming from this community. Since our aim is to have the social aspects of nursing integrated throughout the entire curriculum, participation in curriculum-planning is one of the responsibilities of our visiting instructor. The nursing arts instructor, as she constantly reviews her nursing procedures for simplicity and adherence to basic principles, welcomes the experience of the visiting nurse who through necessity has been forced to reduce her equipment to a minimum. The instructor in medical nursing finds her teaching content revitalized when the community nurse has ready at hand illustrations of home conditions which have been instrumental in causing the disease and will, unless eliminated, inhibit progress toward recovery.

Case-discussion conferences have been held for the staff and head nurses who also share in the development of the student nurse. In these conferences, actual ward patients are used as a basis for discussion. Out of the discussions comes a more realistic understanding of many questions: how home relief recipients may be taught to plan their budgets to assure adequate nutrition; what is the significance of the signs in grocery stores, "We accept food stamps"; what information about the patient may be shared with the family, the visiting clergyman, and the social worker. A better selection of families to be referred to the social service department results. These discussions, too, give emphasis to

the realization that it is the rare individual who comes to a hospital without some form of emotional disturbance.

Working with the students on wards and in clinics helps the public health nursing supervisor to become familiar with the learning activities of the students. This enables her to base her discussions with both graduate and undergraduate groups on actual clinical experiences. When possible she works with a senior nurse who has already had her field experience, and demonstrates to her the many opportunities to become better acquainted with her patients, and to help them in the hospital much as the visiting nurse does in the home.

Renewed contact with the hospital service is in turn a valuable refresher course for the public health nurse, and she brings back to the agency much that is helpful to its own staff education program.

In summary, the public health nurse and her agency are greatly privileged to have an opportunity to assist with the integration of the social aspects of nursing throughout the curriculum. We see as mutually valuable the fact that there develops as a result a more intimate acquaintance between the hospital and community staff members, a more realistic appreciation of their common problems and goals, and hence a better and more smoothly integrated nursing for our community. We are grateful to the nursing school directors for their unfailing patience and understanding as we attempt to improve our methods, and for their constructive evaluation of our progress.

Presented before the N.O.P.H.N. Round Table on Contribution of the Public Health Nursing Agency to the Health Aspects of the Undergraduate Curriculum, Biennial Convention, Chicago, Illinois, May 21, 1942.



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# Treatment Plan for Infected Rejectees

By GRACE C. BRIGGS, R.N.

THE ESTABLISHED service of case-finding and treatment control which is a regular part of the health program in an eastern city of over 500,000 population has proved its value in providing medical care for men rejected by the Selective Service Board because of syphilis.

For six years the State Department of Health has co-operated with the City Department of Health in establishing a comprehensive syphilis control program. It is a large industrial center and the population is made up of many racial groups including a large proportion of Negroes. The usual health problems are complicated because of the large increase in population due to the expansion of old, and the establishment of new, war industries.

Many large industrial plants have long required pre-employment blood tests. Procedures developed for follow-up of cases found by this means were easily adapted for use with rejectees. A new avenue for case-finding was thus opened in an important age group.

Shortly after the passage of the Selective Service Act arrangements were made with the syphilis control service in this city whereby it undertook to carry out certain procedures in relation to men under medical examination for the draft. These procedures have to do with checking all blood test reports, classification of patients as to stage of disease, and their treatment if required.

Under this plan blood specimens from selectees who are examined by the local draft boards are sent to the City Department of Health laboratory for syphilis testing. The reports on these go to the syphilis control service for filing where they are easily detected, being

made out on a special form. Positive and doubtful reactions are checked as received with the roster of previously reported cases. If information on a rejectee's card has not been previously reported, a visit to his home is made by the nurse, or a letter is sent requesting an interview regarding "a matter of importance to him." To avoid loss of time for those who are employed, office hours and telephone number of the syphilis control service are given. Whenever possible arrangements are made to hold the interview in the control service office where privacy is assured. This offers a better opportunity for securing an adequate history and for discussing other aspects of the case, such as the symptoms and manifestations of genito-urinary diseases, date and results of previous blood tests, and specific data regarding former treatment. The information obtained must be verified to determine the potential infectiousness of each individual patient and to decide upon the type and amount of future treatment.

If the history shows no previous infection a confirmation test is requested which may be made by a physician selected by the patient, at a clinic if desired, or by a health department physician. With the patient's permission the titer reading on his Wassermann test which was made for the Selective Service Board is sent to the physician or clinician. This saves time and assists the second examiner in making a diagnosis.

These young men usually display an interest in securing information regarding syphilis: how it is acquired, its duration, length and type of treatment, the possibility of cure, and how this disease may affect their future in relation to marriage. This paves the way for

discussion of familial and other contacts, the importance of an examination for each contact, and the responsibility of every infected individual for the protection of others. The interview may reveal knowledge of a current pregnancy in the patient's household, and thus provide an opportunity for stressing the particular importance of early antepartum examination to determine if a syphilis infection exists. The interviews with rejectees are as a rule conducted by the nurse, the director of the syphilis control service assisting when it seems advisable.

If a diagnosis of syphilis is established and the man put under treatment, periodic checks are made with his physician or clinic to aid in seeing that he keeps under treatment. With the consent of the patient, examination is also made of familial and other contacts. If

he becomes delinquent his case is followed in the usual manner.

Previously reported cases showing an infection of less than five years' duration and less than minimum treatment—generally considered to be 20 arsenicals and 20 bismuths—are followed up by visits to the physician or clinic designated on the record, to determine the present treatment status and to offer assistance in persuading the patient to complete the treatment.

The program to ensure treatment for rejectees infected with syphilis is still in its infancy, but up to the spring of 1942, 369 individuals with a positive diagnosis had been investigated. Of these, 233 were found to have been previously registered in the positive file of the syphilis control service; and 136, over one third, were designated as new cases.

## THE AMERICAN JOURNAL OF NURSING FOR AUGUST

### Married Student Nurses?

#### The Heroic Nurses of Bataan and Corregidor

A County Nursing Council ..... Mary E. York, R.N.

The Government's Subcommittee on Nursing ..... Alma C. Haupt, R.N.

The Kenny Method ..... Jessie L. Stevenson, R.N.

Student Reserve of the Red Cross Nursing Service..... Gertrude S. Banfield, R.N.

Standards and Nursing Education..... George F. Zook, Ph.D.

Making Democratic Ideals Effective ..... John Dale Russell, Ph.D.

The Development of Leadership Power ..... Ordway Tead

Emergency Sanitation Procedures ..... Ralph E. Tarbett

Teaching Women About Prenatal Care..... Hazel Corbin, R.N.

A Home Delivery Service ..... Ruth M. Olson, R.N.

Nursing in a Migratory Labor Camp..... Mary Lee Brown, R.N.

Present Nurse Practice Acts..... Marguerite A. Jacobsen, R.N.



## NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

### MORE ORTHOPEDIC SCHOLARSHIPS

THE RENEWAL of its grant to the N.O.P.H.N. and the N.L.N.E. for scholarships to prepare nurses for orthopedic teaching and supervising positions in public health agencies and hospitals is substantial recognition by The National Foundation for Infantile Paralysis of the importance of nursing in the care of patients with orthopedic disabilities. Nurses and others who are interested in obtaining further information about the scholarships should write to the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York, N. Y. No applications can be considered after October 1, 1942.

### FIELD SERVICE

Several members of the staff have been engaged in field services in connection with two studies currently being made by the N.O.P.H.N. Sybil Palmer Bellos and Evelyn C. Nelson have visited a number of communities in the northeastern area of the country in connection with the study of nursing services in clinics; Mrs. Bellos and Hortense Hilbert have been in the Midwest to study organized community nursing resources for care of the sick.

In response to a request from the Fort Wayne, Ind., Visiting Nurse League, Ella L. Pensinger spent the last two weeks of June gathering data on the nursing services of that agency.

On June 26 Mary C. Connor was in Washington, D.C., at a conference in the U. S. Public Health Service.

Carmelita Calderwood of the Joint Orthopedic Nursing Advisory Service attended a demonstration of the Kenny method of treatment for infantile paralysis on June 12, at the American

Medical Association convention in Atlantic City.

### HONOR ROLL

More than a thousand public health nursing agencies have received their Honor Roll certificates for 1942! We are confident that many more agencies are eligible for certificates but have failed to notify the National office.

As soon as your nursing staff is enrolled 100 percent in the N.O.P.H.N. do let us know so that the name of your service (one-nurse services also) may be included in the next list published in this magazine.

#### ALABAMA

Washington County Health Department,  
Chatom

#### ARIZONA

St. Cruz County Health Unit, Nogales

#### COLORADO

Pueblo County Public Health Nursing  
Service, Pueblo

#### CALIFORNIA

\*Coalinga Elementary and Secondary  
Schools, Coalinga  
Roseville City Grade School District,  
Roseville

\*Visiting Nurses of San Diego, Inc., San  
Diego  
Santa Maria Union Valley High School,  
Santa Maria

#### CONNECTICUT

Canton Public Health Nursing Associa-  
tion, Inc., Collinsville  
Metropolitan Life Insurance Nursing  
Service, Norwalk

#### FLORIDA

Walton Okaloosa County Health Depart-  
ment, DeFuniak Springs

Duval County Health Unit, Jacksonville  
\*Hillsborough County Health Depart-  
ment, Tampa

#### GEORGIA

Southwestern Regional Office of Georgia  
Department of Public Health, Albany  
Burke County Health Department,  
Waynesboro

\*Agencies which have been on the Honor Roll  
for five years or more.

**IDAHO**

Boise City Public Health Department,  
Boise

**ILLINOIS**

DuPage County Tuberculosis Sanatorium  
Board, Glen Ellyn  
University of Illinois, Division for Handi-  
capped Children, Springfield

**INDIANA**

Evansville Public Schools, Evansville  
\*Delaware County Tuberculosis Associa-  
tion, Muncie  
Jasper County Public Health Nursing  
Service, Rensselaer  
Vigo County Nursing Service, Terre  
Haute

**IOWA**

Scott County Nursing Service, Davenport  
\*State Services for Crippled Children,  
Iowa City

**KANSAS**

\*Visiting Nurse Association, Kansas City  
Trego County Public Health Nursing  
Service, Wakeeney

**KENTUCKY**

John Hancock Life Insurance Nursing  
Service, Covington

**MARYLAND**

Metropolitan Life Insurance Nursing  
Service, Hyattsville

**MASSACHUSETTS**

\*Dedham Emergency Nursing Association,  
Dedham

**MINNESOTA**

Public Schools, Alexandria  
Sand Beach Sanatorium, Lake Park

**MISSOURI**

State Board of Health, Fredericktown  
Webster County Public Health Nursing  
Service, Marshfield  
Missouri State Board of Health, District  
Health Office No. 6, Monett  
Metropolitan Life Insurance Nursing  
Service, Sedalia  
Missouri State Board of Health, District  
Health Office No. 2, Sikeston

**NEBRASKA**

Nebraska Tuberculosis Association,  
Omaha

**NEW HAMPSHIRE**

\*Pittsfield District Nursing Association,  
Pittsfield

**NEW YORK**

\*Buffalo Tuberculosis Association of Erie  
County, Buffalo  
\*Town of Marlboro Nursing Service,  
Marlboro  
New York State Department of Health  
in Hamilton County, Saranac Lake  
\*Metropolitan Life Insurance Nursing  
Service, Tonawanda

**NORTH CAROLINA**

Cartaret County Health Department,  
Beauford

**NORTH DAKOTA**

\*Cass County Public Health Nursing  
Service, Fargo

**OHIO**

General American Tank Car Corporation,  
Masury  
\*Metropolitan Life Insurance Nursing  
Service, Middletown  
\*Metropolitan Life Insurance Nursing  
Service, Zanesville

**OKLAHOMA**

District No. 1, Co-operative Health Unit,  
Tahlequah  
Co-operative Clinic, Tulsa  
\*Tulsa County Public Health Association,  
Inc., Tulsa

**PENNSYLVANIA**

Kutztown Visiting Nurse Association,  
Kutztown  
Visiting Nurses Association of Hazleton  
and Vicinity, West Hazleton

**RHODE ISLAND**

\*Jamestown Chapter, American Red  
Cross, Jamestown

**TENNESSEE**

Henderson County Health Department,  
Lexington

**TEXAS**

\*Texas Tuberculosis Association, Austin  
Corpus Christi Nueces County Health  
Unit, Corpus Christi  
Methodist Hospital, Dallas  
Orange City-County Health Unit, Orange  
Texarkana-Bowie County Health Unit,  
Texarkana

**UTAH**

Department of Nursing Education, Uni-  
versity of Utah, Salt Lake City

**VIRGINIA**

\*Charlotte County Health Department,  
Charlotte Court House

**WASHINGTON**

Skagit County Health Department,  
Mount Vernon

**WEST VIRGINIA**

Monongalia County Health Department  
and Public Health Training Center,  
Morgantown

**WISCONSIN**

Waupaca County Health Department,  
Waupaca  
Metropolitan Life Insurance Nursing  
Service, Wausau

**ALASKA**

U. S. Department of the Interior, Alaskan  
Indian Service, Chitina  
Matanuska Valley Community Health  
Service, Palmer  
Wrangell Department of Health, Wrangell



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EDITED BY EVELYN C. NELSON

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#### DEVELOPMENTAL DIAGNOSIS

By Arnold Gesell, M.D., and Catherine S. Amatruda, M.D. 447 pp. Paul B. Hoeber, Inc., New York, 1941. \$6.50.

This book, as stated in the preface, "is primarily devoted to methods of diagnosis and to the applications which rest securely on diagnosis." It is directed to "the medical student who in private or public capacity will soon be confronted with varied and exacting problems which concern the developmental welfare both of normal and abnormal children."

The very clear outline of basic principles and methods, the well-illustrated norms of development, and the Growth Trend Chart make this a valuable reference book for the public health nurse. Conduct of the examination, as discussed in Chapter IV, should be extremely helpful in establishing an understanding of the factors involved in the developmental examination as well as an appreciation of the fundamental information and knowledge of problems which should form the basis for advice to mothers in management, routine, and interpretation.

Perhaps the greatest value of this book to the public health nurse lies in the background it gives her for:

1. Interpreting to the mother or parent the need for guidance—not enforced activities or discipline.

2. Appreciation of growth in relation to the child himself rather than in terms of the child next door.

3. Recognition of the possible relationship between the environment in a particular home and the growth of the child.

Every public health nurse dealing with children will find this book of inestimable value.

MARION H. DOUGLAS, R.N.  
*Hartford, Connecticut*

#### EVERYDAY NURSING FOR THE EVERYDAY HOME

By Elinor E. Norlin, R.N. and Bessie Donaldson, R.N. 306 pp. The Macmillan Company, New York, 1942. \$2.50.

Nursing interpreted in its broadest aspects includes the kind of care that will promote growth and maintain life in such a way that health and happiness will result. Such a concept is implied in this book. Almost two thirds of it is devoted to a discussion of the factors which promote health and prevent illness. All age groups are considered. The chapter on the needs and desires of the adolescent is worthy of special mention. However, the period from the end of adolescence until the approach of old age is given only incidental recognition except for adults who happen to be parents.

The home care of the sick is discussed in considerable detail. The procedures

are clearly defined. The reviewer regrets that the authors did not state the basic principles underlying nursing care, preceding the description of the procedures.

The drawings are clear but they are frequently out of proportion. (See pages 47, 48, 59.) The book is readable and will prove useful to the homemaker and as a reference in secondary schools.

ANNA C. GRING, R.N.

*Washington, District of Columbia*

#### CHEMISTRY OF FOOD AND NUTRITION

By Henry C. Sherman, Ph.D. 611 pp. The Macmillan Company, New York, sixth edition revised, 1941. \$3.25.

The student of nutrition has always gone to this book as to an encyclopedia, confident of finding substantiated statements about the history of each food factor, its chemical and physical properties, functions, place in normal nutrition, requirements for it, and food sources; and discussions of related topics which give an understanding of the relationship of food chemistry to our general well-being.

Every chapter of this edition has been carefully revised, and the last half of the book completely rewritten. New aspects include: a rearrangement of the order in which vitamins are discussed; three new chapters on the most recently discovered vitamins; vitamin values expressed in terms of International Units, with weights of the substance whenever possible; and a revision of food values based on available evidence as of January 1941. There is further evidence that our knowledge of nutrition will contribute to the extension of the prime of life if full use is made of the opportunity which this knowledge affords. "The opportunity is stimulating, but the responsibility is heavy."

Professor Sherman's broad point of view is one of the delights of the book; for he is an economist and a sociologist as well as a chemist in his interpretation of the far-reaching significance of recent

discoveries in the science of nutrition, as shown by these quotations:

... economic conditions and the growth of scientific knowledge have focused attention upon the problems of food budgets.

And the benefit which we may clearly and confidently anticipate is much more than merely biological. It relates not only to health but *through* health to social evolution and to ever higher levels of intellectual and spiritual achievement by the individuals who *will* so to develop their innate capacities.

This is a book we can hardly be without. While it is intended for those who have a background of biological chemistry, many of the sections which discuss the practical application of food to health are written in such nontechnical terms that those who have not had training in chemistry and physiology will find real help and inspiration in its pages.

LUCY H. GILLET

*New York, New York*

#### THE MAN WHO LIVED FOR TOMORROW

By Wade W. Oliver. 507 pp. E. P. Dutton & Co., Inc., New York, 1941. \$3.75.

This interesting book describes the life of Dr. William Hallock Park, whose inquiring mind and thoughtful laboratory study of communicable diseases contributed to the development of preventive medicine.

The book covers the major problem in the public health field—that is, the control of communicable diseases, especially that of diphtheria which was one of the outstanding achievements of Dr. Park's life. The volume and quality of laboratory work done by Dr. Park and his colleagues during his brilliant career, such as research on diphtheria, tuberculosis, dysentery, the role of milk in health and disease, pneumonia, and typhoid fever have become part of the heritage of medical and sanitary science.

The concluding chapter gives a summary of Dr. Park's long years of invaluable service in public health. It includes letters, cablegrams, and telegrams which testify to his contributions. They em-

phasize the incalculable value of his leadership, his helpfulness, his critical judgment, and his acknowledged importance in the long struggle for the prevention and amelioration of mankind's bodily woes.

Everyone interested in the history of the development of preventive medicine and public health should read the biography of William Hallock Park.

MARIE C. BUCKLEY, R.N.  
*Chicago, Illinois*

#### SONGS OF THE NIGHTINGALE

An anthology of poetry composed by the nurses of America. 237 pp. Harbinger House, New York, second series, 1942. \$3.

This is the second in a series of volumes of poetry written by American nurses and illustrated, in the 1942 edition, by a nurse, Maud Greenwood. Approximately 300 poems appear in this second volume, and they range from the quite beautiful prize-winning verses to the thinnest possible examples of jingles—the kind of rhymes all of us have tossed together on the occasion of a joke, a welcome gift, or a happy visit. It would seem as if such well-worded, musical verses as those of Mildred E. Wright, Susan E. Carter, and Bertha Berry, as well as the prize winners and some of the others, deserved better company.

It is pleasant to find nurses able to translate their daily professional tasks into verse, and it is reassuring that a number of these poems are thoughtfully expressed, joyous, or, in a few instances, humorous. Good examples of all of these contributions are: *Nowhere Else Tonight* by Jadwiga Moczulewska; *The Hospital* by Jean H. Osborne, a student nurse; *The Trained Nurse* by Kathryn M. Reynolds; *Betty Bastedo* by Elizabeth Margaret Huie; and *Ode to the Perfect Patient* by Ethel Niemi—the last of special importance to student nurses!

In many of the examples of nurses' poetry this reviewer missed simplicity,

a sound knowledge of meter, and originality. A critic of nurses' ability in short-story writing (James Rorty) once remarked that nurses were too conscious of themselves to attain freedom of expression in creative writing. Certainly a more careful culling by the editors would have enhanced the very lovely and sincere poetical expression revealed in the best of the poems.

It is the stated plan of the publishers to "issue a new edition annually, as long as the profession of nursing maintains its interest and creative talent." This seems a laudable plan, and every nurse should be encouraged to try out for recognition along these lines. Every nurse, whether a would-be poet or not, will find great enjoyment in reading the verses of her fellow workers, and public health nurses will find themselves well represented.

DOROTHY DEMING, R.N.  
*New York, New York*

#### OUR SEX LIFE

By Fritz Kahn, M.D. 459 pp. Alfred A. Knopf, Inc., New York, second edition, revised 1942. \$5.75.

This book is translated from the German by Dr. George Rosen. The beginning of the book deals with sexual functions, intercourse, and the hygiene of sex life. Many useful explanations are given but occasional points made by this author are contrary to accepted facts as presented by other authorities. Over half of the printed space is given to problems of sex life under titles such as *The Problems of Fertility*, *The Disturbances of Sex Life*, *The Diseases of Sex Life*, *Prostitution*, *Juvenile Sex Life*, and *The Sex Life of Unmarried People*. The book will appeal to and help some people. It lacks some of the aesthetic intangibles so essential to an understanding of the behavior of men and women.

The reader is conscious of the author's desire to use this book as a means of telling society why his experiences have taught him that basic education for sex



life is so important in the social order. The solutions suggested have many implications for individual adjustments and for planning on the part of group leaders and teachers. The book is written in easily comprehensible form.

HATTIE HEMSCHMEYER, R.N.  
New York, New York

#### PRIMER OF STATISTICS

By William Palin Elderton and Ethel M. Elderton. 86 pp. A. & C. Black, Ltd., London, fifth edition, 1927, reprinted 1936. Available through the Macmillan Company, New York. 85c.

The first edition of this book appeared in 1909. Proof that the 86-page primer is helpful appears in the fact that the 1936 publication is the eighth issue. It is helpful in establishing concepts of

statistical measurements such as medians and quartiles, frequency distributions, even standard deviations, correlation coefficients, and probable errors. A determined perusal of the 86 pages, it has been said, will give a nurse at least a conversational knowledge of the subject of statistics. It would definitely help a person about to take a university course in statistics. The book is English. Tabulations of cricket scores are often used. Other illustrative materials are coin tossings and length and breadth of shells. The material might arouse curiosity, even doubt, and lead to personal collecting of data on such things as coin tossing—not an undesirable reaction.

D.E.W.

#### RECENT PUBLICATIONS AND CURRENT PERIODICALS

##### WARTIME

CHILDREN WHO WORK ON THE NATION'S CROPS. Gertrude Folks Zimand. National Child Labor Committee, 419 Fourth Avenue, New York, N. Y. 19 pp. Single copies free.

CLUB PROGRAMS FOR VICTORY. The Modern Homemaker. *McCall's Magazine*, Dayton, Ohio. 22 pp. 25c.

Suggestions for groups and communities regarding how they can organize consumer programs.

OFFICE OF CIVILIAN DEFENSE WILL AID ESTABLISHMENT OF BLOOD AND PLASMA BANKS. *The Journal of the American Medical Association*, March 28, 1942. The American Medical Association, Chicago. 25c single copy.

Hospitals in communities exposed to war hazards will have assistance in establishing blood and plasma banks as outlined in this article.

ATTACKING ON SOCIAL WORK'S THREE FRONTS. Shelby M. Harrison. Russell Sage Foundation, 130 East 22 Street, New York, N. Y., 1942. 30 pp. 15c single copy.

A discussion of social work services in relation to the war, as outlined by the president of the National Conference of Social Work.

PAMPHLETS AVAILABLE FROM THE OFFICE OF CIVILIAN DEFENSE, Washington, D. C.

Suggested Regulations for Theaters (Concert Halls—All Enclosed Amusement Places) for Blackouts—Air Raids. 12 pp.

Treatment of Burns and Prevention of Wound Infections. 11 pp.

Central Control and Administration of Emergency Medical Service. 14 pp.

Suggested Regulations for Large Apartment Houses in Blackouts and Air Raids. 19 pp.

A SET OF PAMPHLETS prepared by and available from The Women's Interests Section, War Department, Bureau of Public Relations, Washington, D. C., 1942. Free.

Fit to Fight . . . and Fit for Life. 22 pp.

The Soldier and His Recreation. 27 pp.

The Soldier and his Food. 26 pp.

The Soldier and his Uniform. 19 pp.

The Soldier and his Housekeeping. 19 pp.

The Soldier and his Health. 25 pp.

The Soldier and his Religion. 17 pp.

PHYSICAL STATUS OF YOUNG MEN, 1918 and 1941. George St. J. Perrott. *The Milbank Memorial Fund Quarterly*, October 1941, p. 337. 25c single copy.

An interesting and significant article based on results of selective service examinations.

## INDUSTRIAL NURSING

PROCEEDINGS OF THE FOURTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH. Council on Industrial Health. Reprinted from *The Journal of the American Medical Association*. American Medical Association, Chicago, 1942. 42 pp. 25c.

INDUSTRIAL HYGIENE AND OCCUPATIONAL DISEASES. Course Outline and Digest of Lectures Given in Co-operation with the National Conservation Bureau. Center for Safety Education, Division of General Education, New York University, New York, 1941. (Mimeographed.) \$1.25.

This has been re-issued, including a newly prepared index at the same price. Those who have already purchased the book minus the index may obtain the index free of charge through the Center for Safety Education.

## TUBERCULOSIS

TUBERCULOSIS AMONG NURSES. Jessamine S. Whitney and Helen Jane Stofer. National Tuberculosis Association, 1941. 31 pp. Available through local and state tuberculosis associations.

All nurses will be interested in this summary and discussion of articles regarding the prevalence of tuberculosis among nurses.

LET US LOOK AT THE FACTS. National Tuberculosis Association. 1940. 11 pp. Available free from the local and state tuberculosis associations.

A useful pamphlet for the general public, teachers, and nurses.

## GENERAL

A MANUAL OF FRACTURES AND DISLOCATIONS. Barbara Bartlett Stimson, M.D. 214 pp. Lea & Febiger, Philadelphia, 1939. \$2.75.

This book is intended primarily for medical students and general practitioners but it should be of interest to nurses working in orthopedic programs. The illustrative drawings are excellent.

PROGRAMS FOR MEETINGS OF NURSES' ALUMNAE ASSOCIATIONS. PROGRAMS FOR MEETINGS OF DISTRICT NURSES' ASSOCIATIONS. American Nurses' Association, 1790 Broadway, New York, second edition revised, 1942. 20 pp. 25c.

Suggestions for chairmen of committees on program.

BIBLIOGRAPHY ON HEALTH EDUCATION MATERIAL. American Red Cross. Available free through area offices. Eastern Area, American

Red Cross, 615 North St. Asaph Street, Alexandria, Virginia; Midwestern Area, American Red Cross, 1709 Washington Avenue, St. Louis, Missouri; and Pacific Area, American Red Cross, Civic Auditorium, Larkin and Grove Streets, San Francisco, California.

PERSONAL HYGIENE APPLIED. Jesse Feiring Williams, M.D. W. B. Saunders, Philadelphia, seventh edition revised, 1941. 529 pp. \$2.50.

CHILD PSYCHOLOGY. Charles E. Skinner and Philip Lawrence Harriman. The Macmillan Company, New York, 1941. 522 pp. \$3.

PUBLIC HEALTH EXPANDS ITS FACILITIES UNDER TITLE VI, FEDERAL SOCIAL SECURITY ACT. E. R. Coffey, M.D. *American Journal of Public Health*, April 1941, p. 297. 50c single copy.

An excellent resumé—useful for ready reference—of the program and accomplishments under Title VI, the public health section of the Social Security Act.

CANCER AND ITS CARE. 48 pp. American Society for the Control of Cancer, Inc., 1941. Single copies free from state divisions of the Women's Field Army of the American Society for the Control of Cancer, Inc.

Every nurse will want to own a copy of this pamphlet of up-to-date information on the care of cancer.

"CRACKING UP" UNDER THE STRAIN. Edgar V. Allen. Reprinted from *Hygeia*, the American Medical Association, Chicago, 1941. 10c.

An interesting and sound discussion of reasons for strain and tension applied particularly to business executives. Concludes with practical suggested remedies.

FOOD VALUES OF PORTIONS COMMONLY USED. Anna dePlanter Bowes and Charles F. Church, M.D. 35 pp. Anna dePlanter Bowes, Philadelphia Child Health Society, 311 South Juniper Street, Philadelphia, 1942. \$1.

Public health nurses will welcome this pamphlet as a quick and authoritative reference on nutritive values of various foods.

LOCAL INITIATIVE FOR ORGANIZED MEDICAL CARE. Leslie Orear. *Medical Care*, p. 157. The Williams & Wilkins Company, Baltimore, Maryland, Spring 1941. Published quarterly. \$1 single number.

A symposium of articles describing health programs of labor unions to meet the needs of their members.

## Nurses, to the Colors!

NURSES everywhere will want to study the selective list of classifications of nurses in their relationship to the war effort, which the National Nursing Council for War Service has recently prepared. In full realization of the nursing needs of the military services which *must* be met, while at the same time the health of civilians at home demands protection, the Council offers this help to the thousands of nurses who must decide whether to go or stay. By means of this list each nurse can analyze herself and the professional service she gives in order better to judge where her first duty lies. Before a decision is made the Council asks that the nurse and her advisers accept four basic assumptions:

1. The armed forces must have adequate nursing care.
2. There are not enough additional nurses to allow "service as usual."
3. Voluntary adjustment of supply and distribution of nursing service is the national policy in the present state of the war.
4. "All out" assignment of nurses eligible for military services may be made necessary by changing war conditions. If it is, revision of classifications will result.

Nurses are given the following categories for their personal guidance:

*You should serve with the military forces if you are single, under 40, and are*

1. Doing private duty
2. On a hospital general staff
3. Head nurse in a hospital not essential for teaching or supervision
4. A public health nurse not essential for maintaining minimum civilian health service in any given community
5. In a non-nursing position
6. An office nurse

*You should serve at home if you have a position*

1. In a hospital which has a school of nursing as
  - a. administrator in a key position
  - b. instructor
  - c. supervisor
  - d. head nurse, in a position related to teaching or supervision
2. In a hospital without a school of nursing as
  - a. administrator
  - b. supervisor
3. In a public health agency as
  - a. administrator
  - b. teacher and supervisor
  - c. staff nurse for maintaining minimum civilian health services in any given community
  - d. industrial nurses

In this definition of priorities for nursing service, the council further emphasizes the need for a committee on supply and distribution in every local nursing council for war service, pointing out that each individual nurse must have competent advice, taking into full account conditions in her community. Equitable allocation of nursing service between military and civilian needs inevitably depends on accurate and swift evaluation of their requirements. The army and navy have not delayed in stating their needs. Communities have not been so prompt in adjusting their own programs so that both military and community needs can be satisfied in the best manner possible under present difficult circumstances.

These are the questions that must be answered in every community: 1. Where are nurses now? 2. Where should they be? 3. How can the most necessary of their peacetime services be carried on when such large numbers have been assigned to the armed forces? Obviously only a group representative of all the

(Continued on advertising page 8)

# NEWS

## O. C. D. LITERATURE

A RECENT communication from the Civilian Mobilization section of the Office of Civilian Defense states that the Office of Facts and Figures has transferred to the OCD a major responsibility for the relations of the Federal Government with national organizations. Accordingly, the OCD from time to time sends to the N.O.P.H.N. certain programs and publications of the various war agencies. Much of this interesting material concerns nurses as citizens rather than as nurses. Limited space prevents systematic listing in the magazine. However, all these materials will be kept on file, while they are of current significance. If our readers will define their needs in relation to such information—largely social and economic as it relates to the total war effort—a list will be lent them, and subsequently, on request, specific articles. The most recent publications received are releases from the Office of Price Administration, including "General Price Control," on the whys and wherefores of inflation; "Gasoline Rationing," an explanatory memorandum; "Recipes to Match Your Sugar Ration," self-explanatory; "Radio War Guide," suggestions for understanding the relative program importance of factual war information on the radio, and general program ideas, also for radio use.

## URGE REVIEW OF POLICIES

CONCERNED with the serious shortage of graduates and student nurses and the difficulty of attracting well-qualified young women into schools of nursing, the Subcommittees on Nursing and Hospitals of the Health and Medical Committee, Office of Defense Health and Welfare Services, in April 1942, passed

a resolution asking hospital authorities to review personnel policies effective in their institutions in relation to accepted professional standards. The resolution emphasized the steadily increasing demand for nurses in military and civilian services, and the fact that many graduate nurses are being attracted into other occupations because of more favorable employment and salary conditions. The Subcommittees feel that graduate nurses may be encouraged to remain in institutional service rather than go into non-nursing work, and that the recruitment of student nurses can be greatly accelerated, especially if working conditions and financial returns in nursing are improved. The revised "Manual of the Essentials of Good Hospital Nursing Service," prepared by the Joint Committee of the American Hospital Association, the National League of Nursing Education, the American Nurses' Association, the American College of Surgeons, and the American Medical Association is named as the source of information on personnel policies. Copies of this handbook may be obtained from the National League of Nursing Education, 1790 Broadway, New York, N. Y.

## EMERGENCY MEDICAL SERVICE

THE RELATIONSHIP of various units of the Emergency Medical Service to the Control System of the Citizens' Defense Corps and the Civil Air Raid Warning System is explained in Bulletin No. 4 of the Medical Division of the United States Office of Civilian Defense. The Control Center is the community headquarters of the commander of the Citizens' Defense Corps. Here is received all information essential for operating civilian protective services during an emergency—air raid warnings,

reports of damage caused by enemy action. All orders for services needed are issued from this center. On the yellow or first warning, the chief of Emergency Medical Service—who is in charge of the operation of all the medical units connected with this program—reports to the Control Center. He is now ready, if the red or action warning comes following the blue or lights-out warning, to send help to points where it is most urgently needed, summon outside help, or send services to other areas. Under his direction are the hospital and casualty stations, the emergency medical field units and reserve units, ambulances, casualty information centers, mortuaries, and many auxiliary services such as stretcher teams, medical supply depots. The local Red Cross disaster relief services—canteen, reclothing, rehousing, and others—are also under direction of the commander of the Citizens' Defense Corps, but keep their identity as Red Cross service units.

- Members of the Navy Nurse Corps are being assigned to Navy shipyards and ordnance plants where they will act as industrial nurses. Those with public health or industrial experience are being chosen for this special service.

- Federal funds have been made available under the Community Facilities Act for the development of day care centers in defense areas. Centers conducted in schools variously provide for care of children before and after school hours, by means of nursery schools, serving of meals, health service, and other facilities. Such centers are subject to approval by the Office of Education and are supervised by the state departments of education. Day care projects conducted by other appropriate community agencies must be reviewed and certified by the Children's Bureau before grants-in-aid can be secured. The state welfare department

in such cases is usually the supervising agency. The Children's Bureau requires that day care centers must fit into a community over-all plan, be primarily for children of mothers working in defense industries, and conform to standards and regulations set by state welfare and other government departments.

- Beginning in September 1942, Columbia University will offer a program of professional studies for the training of physical therapy technicians. Training and instruction has been organized in compliance with the requirements set down for such programs by the Council on Medical Education and Hospitals of the American Medical Association. The course is being set up in University Extension in close contact with other departments. Clinical and laboratory instruction will be given at the Vanderbilt Clinic, Neurological Institute, Presbyterian Hospital, and New York Orthopedic Dispensary and Hospital.

Two years or 60 semester hours of college, including courses in physics and biology, shall be required, or graduation from an accredited school of nursing or an accredited school of physical education.

A Certificate of Proficiency in Physical Therapy will be granted to those completing the course. Further information may be obtained by writing the Office of the Committee on Physical Therapy, Room 303B, School of Business, Columbia University, New York, N. Y.

- The Writers' War Board, 122 East 42 Street, New York City, has asked the N.O.P.H.N., "Will you do a job for the Office of War Information?" Stories are wanted about what American communities are doing in connection with the war effort—on farms, in factories, homes, churches, schools—anything. Stories or reports may be any length up



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to 1000 words, written in finished form for publication or merely factual to be rewritten by government writers. Public health nurses have thousands of such stories to tell, about the "ingenuity, resourcefulness, and imagination of the people of America at war." In fact, who more than public health nurses in wartime reveal these very qualities? Send your stories to the Board at the above address. Rex Stout is chairman, and the Board includes such people as Clifton Fadiman, Pearl S. Buck, and William L. Shirer—about a dozen in all.

## Nurses, to the Colors!

(Continued from page 471)

nursing services in the community who can pool their information and plan jointly in common fairness to all can give any kind of intelligent answer to these questions. Certain resources must be considered: (1) nurses actively employed (2) inactive nurses (3) nurses in non-nursing positions (4) student nurses (5) nurses' aides (6) other volunteers and (7) paid auxiliary workers. Certain practices must be abandoned for the general good of all—duplication of nursing services, luxury nursing, and employment of nurses in non-nursing positions.

Nurses who believe themselves to be in the first group should enroll at once in the First Reserve of the American Red Cross for service in the Army or Navy Nurse Corps.

Every agency employing nurses and every individual nurse is urged to get in touch with the local council for war service for guidance as to the needs and distribution of nursing service.

The classifications listed above are contained in a pamphlet that will be widely distributed in the near future. The booklet, "Distribution of Nursing Service During War," which gives advice on how to organize a local nursing council, can be had free on request to the National Nursing Council for War Service, 1790 Broadway, New York, N. Y.

# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## The School Child in Wartime

THE SCHOOL child's regimen of living undergoes many changes in wartime. Some of these changes may be for the better, but many unhappily are detrimental to his health and well-being.

He may be getting better health supervision at home than formerly because his mother has studied home nursing and his father first aid; but quite probably he is getting less care, with his father away from home more of the time on defense duties of one kind or another and his mother's attention chiefly on her volunteer war work or her wartime employment or her absent sons.

He may be better fed, if his mother has taken a nutrition course and has learned how to plan, buy, and prepare more adequate and appetizing meals; but on the other hand, his meals may be more irregular and less carefully prepared because his father is away or is working on the night shift, or because his mother is employed and there is no one to look after his meals.

His living quarters may be better if the family income has increased; but they may be poorer as a result of rising costs, housing shortages, or a broken family.

His recreation is perhaps more carefully planned and supervised, in keeping with the present emphasis on physical fitness for all; but it may be less so due to the time and attention, space, and facilities required to develop physical-fitness programs for his older brothers in the armed forces.

Because of the increased interest in

health at this time, his parents and community agencies may pay more attention to treatment of his physical or emotional handicaps; but they may give him less attention in view of the pressure to rehabilitate the young men rejected for military service on the basis of remediable defects.

Because of the present emphasis on health preparedness, his school may be giving him better health service; but it is just as possible that the school physician is overloaded with examinations of selectees and applicants for vocational courses. And his teacher may give less time and attention to health teaching due to wartime curriculum revisions, such as the current "air conditioning" of pupils to give them a foundation for aeronautical education.

The nurse working in the school must have all these possibilities in mind—and more. But what can she do about these problems? Whether she is giving a general family health service or a specialized school nursing service, her official load, as well as her extracurricular activities, has probably increased. In addition to her regular duties, she is presumably working with her local nursing council for war service on an analysis of the community's nursing needs and on the possibilities for pooling resources in order to use available nursing service most effectively.

She must also analyze the health needs of her school to be sure that a clear picture of the school health situation is included in the community study. With her principal and school physician she

must consider what additional responsibilities the school should assume to help the community meet the many and urgent demands made by the war. ("Vocational School Prepares for Emergency," by Ruth V. Bien, in *PUBLIC HEALTH NURSING* for April 1942, discusses one school's wartime activities.) In some instances she must help protect the school against unwarranted assignments of duties; in others, she should be the one to see most clearly why the school is the best fitted of all the community agencies to assume a particular service.

The nurse whose work has become more and more highly specialized has an acute personal problem to meet, for she must find ways (and her employer must help her find them) to bring herself up to date on other aspects of public health nursing, including bedside care. In the event of emergencies that result in heavy casualties, additional nurses will be needed to staff the hospitals and to give home care to patients evacuated from hospitals to make room for the injured. With an increasing proportion of professional nurses in military service, these tasks will rest on those who are left in the community. If hospital loads should be suddenly increased by war casualties, the most important duty for all nurses—public health included—may be to give nursing care in homes and hospitals. In preparation for such responsibilities, many nurses will need to acquaint themselves with new procedures.

How is the nurse in the school to do all these things? There is no easy answer. But certainly she needs a readiness to make adjustments, the ability to put first things first, knowledge of how to use volunteer service when possible, and an aptitude for simplifying the mechanics of her job and perfecting techniques of co-operation within and without the school.

The following check list, prepared to help one group of school nurses appraise their activities and determine whether

they are making their contribution to the war effort, may be helpful to others.

1. Are you participating in the community planning for distribution of local nurses to carry out essential nursing services in the face of depleted personnel, and to meet new community needs?

2. Are you helping to complete the national nursing inventory and keep it up to date by finding inactive nurses in new families who have moved to the community?

3. Are you doing your part in recruitment of students for schools of nursing? In educational guidance of your high-school students, are courses prerequisite for schools of nursing given consideration? In vocational guidance, are the various types of nursing education featured: (1) the collegiate course (2) the basic three-year nursing course (3) the course for practical nurses or auxiliaries?

a. Does your school have on file the catalogues of the schools of nursing in your area?

b. Are attractive and authoritative books of fiction on nursing (such as the series by Dorothy Deming, published by Dodd, Mead and Company, New York) available in both school and public libraries?

c. Are movies on nursing and speakers from schools of nursing featured on assembly programs?

d. Is information on how to choose a school of nursing available to prospective students in your community? (Pamphlets giving information on how to prepare for nursing may be obtained from the Nursing Information Bureau, 1790 Broadway, New York, N.Y.)

e. Do the girls and women of your community know that you will assist qualified students in obtaining admission to a school of nursing, and in securing financial help for the course, if necessary?

4. Are you helping to plan courses for Red Cross Volunteer Nurse's Aides, recruiting students for the courses, and assisting with plans for the effective use of volunteers in your own program?

5. Is your school making specific efforts to lessen the need for medical and nursing care of pupils by reduction of preventable accident and illness?

(Continued on page 512).

# Nurse in Wartime School Health Program

By RUTH E. GROUT, Ph.D.

**L**IFE FOR most girls and boys returning to school this fall is very different from what it was a year ago. There is hardly a child who has not been affected in some way by the war. Homes have been disrupted by men being called away for service in the armed forces, industry, or agriculture, and by mothers entering war work.

Many conditions have developed which have resulted in increased hazards to health. Trailer camps, crowded housing conditions with accompanying exposure to disease are no longer exceptions in many war areas. Increased tensions, decreased supervision in family life, and other phenomena associated with war contribute to health problems which are made even more serious by the acute shortage in doctors and nurses.

The schools are in the front line of institutions which will bear the impact of these problems. It is in the interest of the children as well as in the schools' own interest that they do everything possible to prevent the problems from developing. Those of us who are charged with responsibility for school health are faced with new demands on our skill and resources, demands which in every community must be met realistically and promptly—and with imaginative foresight.

What are some of these new demands which the schools, along with other agencies, must meet if they are to do their part in maintaining health and morale on the home front? How may the public health nurse working in schools share in these new responsibilities? These are pertinent and important questions.

Three community responsibilities

mentioned here because of their special significance at this time are:

1. Provision of day-care program for children of working mothers.
2. Preparation of youth for services on the home front and in the armed services.
3. Training of leaders for school and community health work.

These are singled out not so much because they are necessarily more important than other responsibilities but because of their newness and the fact that in many quarters they have not been fully recognized, much less delineated. These responsibilities are presented here as problems to challenge the skill, resourcefulness, and organizing ability of the public health nurses working in schools.

## CHILDREN OF WORKING MOTHERS

The Bureau of Labor Statistics, U. S. Department of Labor, and the U. S. Employment Service have estimated recently that there are two and one-half million women now employed in war production. By December 1942, four million women and by the end of 1943, six million women will be employed in war production according to these estimates.\* In addition, large numbers of women will be working in civilian activities. Obviously new recruits to industrial ranks will comprise increasing percentages of women with dependent children.

Many women will be working in large industrial cities where the need for care and supervision of their chil-

\*Unpublished data obtained from Day-Care Section, Office of Defense Health and Welfare Services, Washington, D.C., August 1942.

dren during working hours long has been recognized but now has grown in intensity. In these cities, action must be taken to expand and further coordinate existing facilities. In smaller cities which almost overnight have grown to several times their original size through the influx of war workers and their families, facilities are likely to be fewer, perhaps nonexistent, and community leadership is often less developed. Here competent leadership must be located and adequate programs developed.

In every community where the problem may exist, a careful study should be made by interested agencies to determine its exact nature and extent. When once the problem has been defined, a form of organization should be worked out and responsibilities so delegated that all available community resources for care of children are used to their fullest.

Since sooner or later many of the problems of childhood come to a focus in the schools, it is logical to assume that in most communities the schools should have an important part to play both in planning and carrying out programs of child care. These programs should and can be of such quality that the children will gain and not lose by the experience.

In any program, special care will be needed throughout the day for children between the ages of two and five, and before and after school and during vacation periods for children from five to fourteen. In the care of both groups lies a definite challenge to schools.

Standards for child care and guidance have already been established with respect to personnel, program, plant, and equipment.<sup>1</sup> Included in these standards are provisions for health care such as: (1) measures for prevention of communicable disease and accidents (2) attention to correction of remediable defects (3) provision for proper nutrition (4) provision for plants and facilities

which conform to certain specifications with respect to such needs as safety, sanitation, light, ventilation, and temperature.

#### NURSE IN DAY-CARE PROGRAMS

Now what does this all mean to the public health nurse? How can she contribute to a child-care program, and be of special assistance to schools and other groups which will assume the major responsibility?

She is in an especially strategic position to give help from the start. On her home visits, in her clinic contacts, and in her work with welfare groups, the public health nurse has a world of opportunity to collect facts about specific children which will be invaluable in the development of the programs. Who are the mothers on her roster and how many of them are at work? Where are their children being cared for and by whom? What attention is being given to their physical welfare? Are they getting adequate meals, or enough sleep? Where do they play, and with whom? These and many other facts must be known, not just as statistical data, but as vital elements that affect the individual children the nurse may know, and as facets of the general problem which must be solved by community action. With such specific and practical facts she can make a real contribution to the delineation of the problem and toward starting the program in the right direction. As the program develops, and health guidance for children, parents, and teachers is needed, her services as a nurse will play a most important part in the success of this very important phase of our war effort.

#### YOUTH IN WARTIME SERVICE

School-age youth throughout the land already are giving evidence of their eagerness to serve in whatever capacity they can to help win the war. During this crop season, thousands of nonfarm boys and girls are laboring on farms to



keep food production rolling, a contribution which is likely to be of vital importance to all of us in this and succeeding war years. Hundreds of thousands of others are undergoing training so that they can serve better in industry and the armed forces.

School curricula and schedules are being geared to give youth the opportunity for training and service, and the coming school year will find many changes directed toward this end. In some localities youth service corps are already organized to give young people the opportunity to join together in such war services as civilian defense activities, salvage campaigns, and food production and conservation, and to obtain pre-induction training in preparation for joining the armed forces. Moreover, a movement is on foot to encourage such organized efforts throughout the educational systems of the country.

In order to do effectively the jobs which lie ahead, young people want and need a sound body with a reserve of stamina and vitality. Parents and schools are coming to recognize that they have a grave responsibility both in helping youth attain the fitness needed for service and in guiding youth into forms of service which are health building.

#### HEALTH FOR OUR YOUTH

The health implications in this new service program are many. Youth who already have sound bodies must be toughened and conditioned further through power-building and skill-producing physical activities, and physical fitness programs must be provided to make this possible. Youth with defects and other handicapping conditions must have these conditions removed as far as possible, and all youth must be better trained to look after their own health.

There are health and safety hazards as well as responsibilities connected with the different forms of service, which

should be recognized by youth and their parents, leaders, or employers. Steps have already been taken by the U. S. Office of Education to point out the health and safety factors associated with emergency farm work for youth. In a recent issue of *Education for Victory*<sup>2</sup> an analysis was made of these factors. Parts of it are reproduced here:

#### Questions each youth may face:

##### A. In preparation for the job—

1. Have I had a physical check-up to make sure that I am in condition to do heavy farm work?
2. Can I recognize common poisonous plants, reptiles, and insects where I work, and do I know the necessary treatment should I be poisoned?

##### B. On the job and after working hours—

1. Am I including a rich supply of protective foods, such as milk, eggs, fruits, and vegetables, in my diet to give me health and vitality?
2. If working under extreme heat, do I take extra salt to replace salt lost through excessive perspiration, thus preventing heat exhaustion?

#### Questions each community and individual employer may ask:

##### A. Health provisions for youth in respect to working conditions—

1. Is some one responsible for observing the effect farm work is having on the health of each youth?
  - a. Beneficial signs
  - b. Danger signs
2. Are youth being hardened gradually into heavy work?

##### B. Health provisions for youth living in homes of farmers—

1. Has an agreement been reached with parents regarding the nature of medical services which would be used in case of an emergency?
2. Have water supplies been tested and approved by public health authorities?
3. Is reasonable attention given to furnishing clean individual drinking cups as a means of preventing spread of mouth infections, colds, and other diseases?

##### C. Health provisions for youth living in camps, vacated school buildings, et cetera, and commuting to farms for work—

1. Is medical and nursing guidance available?
2. Is there adequate refrigeration for food?

3. Are evening recreation centers and sleeping quarters screened? (Especially important in malarious sections.)
4. Are provisions made for isolating and caring for cases of communicable disease?

Similar analyses are needed for other forms of service, such as industrial labor and care of children. The public health nurse, in her contacts with schools as well as with individual boys and girls and their parents or employers, can be of special service in pointing out these health factors and giving counsel concerning them.

#### TRAINING NEW LEADERS

The new demands which are being made on schools and communities in the face of a growing shortage of medical, nursing, and teaching personnel, make it imperative that leadership be developed to take over some of the load formerly carried by specialists. Teachers, parents, community workers, and pupils themselves, if properly trained, can relieve the professional health personnel of much routine work and give them more time for their specialized medical and nursing tasks.

Teachers can participate more actively today in health examination procedures—and in many places are doing so. The teacher who knows how to observe her children for signs of deviations from normal health and who ties these observations to her health education work is a much more useful person in the school health program than one who leaves it all to the doctor or nurse.

In the recent Astoria School Health Study,<sup>3</sup> teachers were trained to observe children daily for such symptoms as:

Eyes—styes, crusted lids, inflamed eyes, crossed eyes, frequent headaches, squints at book or blackboard

Nose and throat—persistent mouth breathing, frequent sore throat, recurrent colds

Absences for illness—colds, stomach or intestinal upset, others

Many of these difficulties might never have been discovered in a perfunctory yearly examination; yet they are significant symptoms indicative of the need for medical supervision. As a result of this Astoria School Health Study,\* teachers in New York City now refer to the doctors only those children who show some special need for medical attention.

In many communities, nurses are training teachers to make the Snellen tests for visual acuity. This not only relieves the nurse of a time-consuming job, but provides an excellent educational experience for the teachers and pupils. Then too, weighing and measuring of children, formerly done by the nurse, are now often carried out by older pupils under teacher supervision. Children are naturally interested in their own growth and many worth-while educational activities can develop from a study of growth.

Home nursing instruction has already been recognized as a means of teaching others better to help themselves so that the nurse may be relieved of nontechnical home nursing work, and family health can be maintained. Home economics teachers are potential allies of the nurses in giving home nursing instruction. Where these teachers are available, every attempt should be made to share the course work with them, planning it so that each handles that part of the course which she is best qualified to teach.

These are only a few examples of the kind of work which can be taken over in part by teachers or others. Numerous suggestions for additional forms of volunteer services are given in a series of booklets on that subject recently published by the Office of Civilian Defense.<sup>4</sup> Copies of these booklets can be secured from local defense councils.

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\* See also "Future Health for the School Child" by Dr. George M. Wheatley on page 483 of this issue.

School health standards can be maintained and new demands met only to the extent to which nurses and other health personnel can relieve themselves of detailed burdens by securing lay assistance. The time required to prepare these assistants for effective service will be well spent even though it may result temporarily in a reduction of personal services.

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<sup>2</sup>U. S. Office of Education, Federal Security Agency. "Health and Safety for Youth in Emergency Farm Work." *Education for Victory*, July 1, 1942, p. 1.

<sup>3</sup>Nyswander, Dorothy B. Solving School Health Problems: The Astoria Demonstration Study. The Commonwealth Fund, New York, 1942. 377 pp.

<sup>4</sup>U. S. Office of Civilian Defense in co-operation with Office of Defense Health and Welfare Services. Volunteers in child care; volunteers in consumer programs; volunteers in family security; volunteers in health, medical care, and nursing; volunteers in nutrition; volunteers in recreation.

## Health of Selectees---Past and Present

THE PHYSICAL STATUS of a group of selectees as observed 15 years ago, when the men were school children, compared with their present physical condition as discovered in recent examinations for military duty is the subject of a significant study by Ciocco, Klein, and Palmer in *Public Health Reports*, December 12, 1941, page 2365. The concluding paragraphs of the study—published under the title, "Child Health and the Selective Service Physical Standards"—are of special interest to those concerned with school health. They are quoted here in full:

These findings indicate that a relatively large number of the selectees who have been rejected because of defective dentition and vision already gave evidence of the same defects 15 years ago when they were in elementary school. It is probable also that some of the selectees rejected for cardiovascular diseases and for ear defects could have been identified when in school. The data relative to the last-named conditions are

not conclusive, but knowledge regarding their etiology and development support such a view. For most of the remaining physical causes of rejection one might suspect that some sign was also present in childhood. There is, however, no way of determining the validity of such an assumption, because the school examinations were not directed toward the discovery of the corresponding defects in childhood. The results of the present study suggest also that growth as measured by weight, posture, and the physician's estimate of the state of nutrition—all traits that are frequently examined to determine the health status of the child—are useful as crude predictive indexes of adult physical development. On the other hand, the condition of the tonsils in childhood does not appear to have much significance in relation to the future physical status of the young adult.

The above data and findings, although based on a relatively small sample, enable us to visualize more clearly some of the fundamental aspects of the much-discussed topic of the physical fitness of

selectees. Surgeon General Parran has recently said: "... if it is stupid to waste money and material ... it is treasonable to waste manpower."\*\* It becomes, therefore, of a great deal more than academic interest to know that we have and have had for years a more or less effective way of predicting long in advance the physical status of adults of the now particularly important early productive ages.

It is particularly disturbing to find that, in spite of knowing, for instance, which children in a community would grow up into physically handicapped adulthood, the health professions, the lay professions, and especially society as a whole, have to date apparently failed to take full advantage of the knowledge.

In the not very remote past, public health and medical care programs have, it seems, been dominated by the concept of mortality, a concept not enlightening with reference to child health since mortality is lowest in childhood. The findings of this study seem instead to reinforce the views held by many that disease in adulthood is often brought about by the cumulative effects over a long period of time of many pathologic conditions, many incidents, some of which take place and are even perceived in early infancy. Consequently, the more information that is available, in concrete and well-defined terms, of the individual's past and present health, the more surely can his future physical status be estimated.

It appears rather obvious, on consideration of the findings presented here, that it is imperative for our national concern to guard to the utmost the health of children. On paper and in theory this

is a view which all have accepted for some time. Actually, in many respects, lack of forethought, lack of planning, or even mistaken notions of execution of plans have apparently prevented the full realization of such a concept. Now it becomes even more essential to pass from theory to practice, to arrive at a definite formulation of what school medical examinations should consist of, what their objectives ought to be, and, more important, to what end the findings are to be used. School medical examinations have in general been characterized by cursorness and superficiality, even though in all fairness it must be recognized that they have produced a usable fund of information. However, as was shown above, the results are quite limited in scope and often less than precise.

If it be true, as few will deny, that the need for competent, healthy, physically fit young men is now and will be, for some years, at an all-time high, then this need must be explicitly recognized and satisfied. Satisfaction of this need involves acquiring information on all significant early (and especially remediable) defects, employing accurate measures of functional status, recording the pertinent information in objective and permanent form so as to serve as both a medical history and a basis for the evaluation of therapeutics, and finally, it involves the necessary corrective work. In these ways it would seem possible to attain not only effective prevention of damage from disease but also effective upbuilding of national physical status.

\*\*Parran, Thomas. Address delivered at the meeting of the American Academy of Pediatrics, Boston, Mass., October 9, 1941.



# Health for Tomorrow's School Child

By GEORGE M. WHEATLEY, M.D.

Implications of the Astoria School Health Study for school health services are discussed in this significant report made at the Biennial Convention

THE LAST World War gave an unprecedented impetus to the school health program. The medical findings of the examination of draftees in 1917 and 1918 stimulated legislation authorizing schools to secure annual examination of pupils. At the time, these laws were hailed as the cornerstone of the school health program. Practically, school medical examination laws have failed to achieve the high hopes held for them because the school has usually assumed complete responsibility for the examination without ever being able to secure sufficient money to employ the medical and nursing personnel to carry out the intent of the laws effectively. The problem of providing health supervision for school children cannot be solved by such legislation nor by one agency working alone. We have all been conscious of the ineffectiveness of some of our school health work.

Today, when prevention of waste of both commodities and services is a *must*, it is possible to ask sternly whether some of our school health practices are wasteful and possibly obsolete? We might, for example, discover we are duplicating service which family physicians or hospital or health department clinics are prepared to render; that the school physician has a more important function than merely to find defects; that around the school nurse can revolve a more meaningful health service; and that the teacher's role can become one of active day-to-day health supervision of her pupils.

Today, when our most pressing medical problems are military and industrial, the most important implications of the Astoria School Health Study\* lie in its method—not its accomplishments in New York City. It is hoped that the spirit of inquiry and analysis which brought about these changes will impress you most, because the wider application of the experimental method is needed in the study of school health service and could be used with profit to study other health services. The full printed report of this study is now available.\*\*

## HOW THE STUDY BEGAN

In 1936, at the request of both the Department of Health and the Board of Education of New York City, the research unit was established with the aid of special funds to study and to devise more effective methods of carrying out school health practices in New York City. This study was the natural outgrowth of recommendations made by the American Child Health Association in 1930-1932. The administrators of the two city departments wished help in finding practical application for the recommendations coming from this earlier research.

\*For previous articles on this study in PUBLIC HEALTH NURSING, see "Modern Tools for School Health," by Marian V. Fegley, September 1939, and "Malnourished Children in the School," by Dr. Wheatley, May 1941.

\*\*Nyswander, Dorothy B. Solving School Health Problems. The Commonwealth Fund, New York, 1942. Reviewed on page 530.



One of the first decisions made by the two city departments—a decision which had the greatest influence in enabling the research unit to flourish—was to make the unit independent of rules and regulations governing the citywide service. Complete freedom was given to facilitate experimentation. The study unit was composed of the director, a staff of two pediatricians, a nursing supervisor, and a health education teacher. The Health Department school health personnel assigned to the unit were five public health nurses and four school physicians. The school physicians served all the 18 schools in the Astoria Health District, although the work of the study was conducted only in eight schools served by the five nurses.

The district superintendent of the Board of Education gave full support to the program, and the district health officer not only gave support, but because of his special interest in school work, inspired many of the procedures which were eventually developed. The eight principals and 239 teachers of the experimental schools gave a full measure of cooperation.

The eight schools in Astoria with an enrollment of approximately 8000 children were chosen because they were considered by the Board of Education as representative of public schools in the city. Among the schools were one or two with children from families of fairly good economic status, and five with children from very poor families. Among the schools was a large junior high school of over 2000 students and one small school with classes from kindergarten to the third grade.

#### NEW PROCEDURES TESTED

In dealing with each problem, the first step was a careful study of the procedure as it was being carried out. Many observations were made under different conditions. When possible, statistical answers were sought to questions regarding the effectiveness of various functions

of the doctor, nurse, and teacher, as these individuals' efforts were directed towards discovering and securing care for children with adverse health conditions. After the data—both narrative observations and statistical studies—were before us, the field staff and the study staff set up plans to correct the deficiencies in the program and to strengthen the good points. Frequently several plans aimed at the solution of the same problem would be tried out, either in different schools or in succession in all of the experimental schools. Weekly conferences, as well as close field supervision by the study staff, were used to measure results of new procedures. Thus needed changes could be promptly introduced.

While new procedures were being tested, a close contact was maintained with the administrative staffs of the Health Department and Board of Education to keep us advised whether our techniques were practical for the city as a whole. Later, when the procedures were accepted by both departments, the staff of the research unit became the instructors of an in-service course in school health to teach the procedures to key Health Department physicians and nurses from all over the city.

The contributions made by the study in relation to three aspects of school health service will be considered here: (1) improvement in administration (2) clarification of the school physician's functions (3) demonstration of staff-education methods.

#### ADMINISTRATIVE IMPROVEMENTS

One of the first administrative measures introduced was a change in the method of transferring the school medical record of each child. A study of the files in the experimental schools revealed that by the time children reached the sixth grade more than 75 percent of them had no medical record. The reason for this loss of records was due to the method of transfer when the child changed schools.

The author describes work of a health center to children in a public school class



In New York City, moving is perennial for 30 percent of the population. With such a rapid turnover, an efficient method of transfer is necessary.

The method formerly in operation was to transfer the medical record through the public health nurses of each school. The difficulty lay in the fact that it was not the custom of the schools to inform the nurse about transfers, and even when the nurse was informed by the school clerk that a child was leaving the school, the clerk could not tell the exact school which the child would enter. It was obvious from the number of lost records that the efforts of the nurse to trace children were unsuccessful.

The new method calls for each school clerk to place the child's medical record in the envelope containing the academic record, and to give this envelope to the parent at the time arrangements are made to transfer the child. A study after one year's operation of this new system showed it to be functioning 80 percent efficiently.

The system of filing the medical records was revised. A medical record in two colors was introduced to identify male and female children. This facilitates the nurse's discussion with the teacher regarding pupils, because class-

room records are filed by sex. It also reduces the time the nurse must take to find a card in her files. Colored tabs are used to enable the nurse to locate quickly those children for whom she has to carry out some function. A blue tab means that the nurse wishes to see the child. A white tab indicates that a child is to be seen by the school physician on his next visit. A green tab tells the nurse she is to see the teacher about the child.

The medical record itself was improved to allow more space for history, physical findings, recommendations, and plan for follow-up. Many of the forms used to secure a health history of the child and to report the result of the medical examination to the family were completely revised. The objective in revising these forms was to produce a favorable impression on the family, with the aim of making them receptive and coöperative. Here again individual colors were used and careful consideration given to the wording of the forms.

In order to provide more effective day-to-day health supervision of the children in the classroom, the teacher's strategic position was capitalized. A pupil health card was introduced to direct the teacher's attention to common signs and

symptoms of poor health which she might observe in her children. No attempt is made to encourage diagnosis by the teacher. In fact, it is actively discouraged; the teacher is expected only to observe symptoms, to make note of them, and to call them to the attention of the nurse. The pupil health card is used also by the school physician and nurse to interpret the child's health status to the teacher. Space is provided for the physician to write his recommendations to the teacher and for the nurse to report progress in follow-up. It is a cumulative record and passes with the child from grade to grade.

#### FUNCTION OF SCHOOL PHYSICIAN

One of the most important accomplishments of the study was to redefine the work of the school physician. The school medical examination was developed so that it more nearly approached the ideal of the health examination. Special study was made of rheumatic heart disease and nutrition so that the school health service might provide more intelligent care of children with such conditions. Teachers and nurses were encouraged to use the physician as a consultant for children with health problems. A system was developed which gave the physician opportunity to examine these children and make recommendations about them to the teachers and nurse. These changes enable the physician to function as a medical adviser in the school.

Four of the more important factors which contributed to improvement of the school medical examination were as follows: (1) presence of the parent at the examination (2) adaptation of the medical examination to the needs of the individual child (3) efficient use of the time of the physician and nurse (4) interpretation to the teacher of the results of the medical examination.

The presence of the parent gives the physician an opportunity to interpret on

the spot any medical findings and to plan with the mother and nurse further care for conditions needing attention. The examination becomes an occasion for the physician to discuss with the parent health problems of the child or needed prophylactic measures such as diphtheria immunization, or to make suggestions toward improving the child's living habits. This face-to-face discussion by the parent and physician is the most important part of the whole school medical examination. Today in New York City, 89 percent of these examinations are performed with a parent present.

By adapting the examination to the needs of the child we mean that the school physician is no longer expected to give a stereotyped examination to every child. The responsibility for thoroughness of the examination in any individual case is placed upon the school physician. This is desirable because it places him on his mettle and brings into play his best professional judgment. It is also a practical necessity because the policy is to encourage both nurse and teacher to refer children freely to the physician for his opinion. The physician is instructed to make one of four possible decisions in each case:

1. The child presents a problem, but the nature of the problem is not evident. It is advisable for the physician to interview the parent and to give the child a more thorough examination in the school.
2. The cause of the child's complaint is so apparent that further examination is unnecessary, but a nurse interview with the parent is recommended to explain the nature of the condition and to plan for care.
3. The child's symptoms or behavior should receive further observation by the teacher, nurse, or physician—to be designated by the physician and recorded on the medical record and health card.
4. No attention is needed. Some explanation should be made to the teacher or nurse concerning the child, if possible.

This is a definite departure from the old routine examination. It appears to

be a practical way not only to provide service for the individual child, but to provide it for the greatest possible number. This policy has contributed to the more efficient use of the physician's time.

Other steps have been taken to conserve the time of both physician and nurse. For example, the physician no longer participates in vision-testing. This is the responsibility of the school nurse and classroom teacher, who manage the entire follow-up program for vision defects. The height and weight are taken by the teacher also, prior to the examination.

#### NURSE'S PART IN EXAMINATION

The time of the nurse is used more efficiently by having her present when the school physician is conducting the examination. She records the physician's findings on the child's school medical record. We found this to be a most effective way for the nurse to participate in the examination. Instead of having to decipher the physician's scrawl on the record at some future date when she is doing the follow-up work, she now makes the record in her own handwriting and is in a position to question the physician concerning details which he has not made clear.

For example, in the course of the examination after the physician has made certain comments as to physical findings, the nurse may ask: "Doctor, do you want me to make a home visit to this child? Should I make it immediately? I still have several visits to make that you recommended only last week. What do you want to know when I visit the home? What shall I say about the need for treatment?" The answers to these questions are put on the record to refresh her memory at a future date. When the nurse is present she is often able to furnish valuable information about the child. While admittedly this ties her up during the physician's exam-

ination, we have found that it saves time in the long run because she has a better knowledge of what was in the physician's mind when he made the examination. She also knows what the parent promised would be done about necessary treatment. Furthermore, one of the important benefits of this participation by the nurse is education of the physician regarding the information which she needs in order to do an intelligent job of follow-up on the results of his medical examination. This teamwork in the school examination has created a new understanding between the school physician and school nurse. Now they more fully realize their interdependence in the successful school health program.

The teacher is brought closer to the examination also by the written report which is sent to her on each pupil's health card. For the teacher, the school physician writes a brief interpretation of his medical examination. This has the effect of acquainting her with special health conditions or adjustments she can make for pupils in her class. This procedure has made the school physician aware of the strategic position of the classroom teacher who observes the child from day to day. He has learned that she can assist him by discovery of children who may be in need of medical attention and by making classroom adjustments based on medical recommendations.

All these improvements in the school medical examination have greatly strengthened the role of the physician in the school. These changes have enabled him to emerge from his drab job of doing routine examinations, to become an important member of the school faculty in a new capacity—that of school medical adviser.

Of particular interest are the new procedures for the management of children with so-called nutrition defects or cardiac defects.

#### NUTRITION DEFECTS

A special study of 5500 malnourished children revealed: (1) Too much reliance was placed on the child's deviation from average height and weight for his age. (2) Follow-up was ineffectual due to inadequate study of the individual child. A procedure was developed which provided for careful clinical investigation by the school physician of each child who, on the basis of physical appearance, is judged below par. The designation "malnutrition" is not applied to children until careful dietary and medical history and medical examination of the child make the diagnosis appropriate. The appraisal of physical appearance takes into account body build, amount of fat and tone of muscle, color of mucous membranes, posture, appearance of vigor, and weight gain from year to year.

#### RHEUMATIC FEVER

Today the most serious disease in the school-age group is rheumatic fever, yet a study of methods employed to discover and supervise children with rheumatic heart disease in the schools revealed great deficiencies. One important defect was lack of consultation service for the school physician. Usually his diagnosis was based on one examination of the child. It was sometimes checked by a medical supervisor no more competent in diagnosing borderline conditions than the staff physician. Then the diagnosis was frequently overruled by the clinic or private physician. When differences arose between the school and the treatment agency, there was no qualified specialist to arbitrate.

Furthermore, it was clear that if the school health staff was ever to be able to bring a different point of view about cardiac children to principals and teachers, instruction was needed to bring the school medical staff up to date on rheumatic fever and heart disease in children. To provide consultation service and to carry on staff-education work with school

physicians, on the recommendations of the study, consultation units were established in the five boroughs of the city. Five cardiologists with training in pediatrics have been added to the school health service of the Health Department to direct these units. A new feature of this service is its availability to school children on request of their family physicians. No treatment is carried on by this consultation service. Its functions are (1) diagnostic for the school health service (2) educational for school physicians and nurses.

Special plans were also developed for the detection and follow-up of dental, vision, and hearing defects. These are fully discussed in the printed report now available. One procedure of special interest to nurses is the teacher-nurse classroom conference.

#### TEACHER-NURSE CONFERENCE

Nurses have always made classroom visits in the New York City system, usually for the purpose of checking up on physical defects of children or giving a hygiene talk to the pupils. Frequently the visit was used as an occasion for the teacher to leave the room. Obviously, the real value of a nurse's visit to the classroom is lost when the nurse talks to the class and the teacher steps out of the room. The teacher is better equipped to teach hygiene to pupils. The nurse should be able to give her authentic facts and materials on which to base her teaching. The study instituted the conference method between the teacher and the nurse with the dual purpose of keeping the teacher informed about the nurse's progress in follow-up, and at the same time providing the means of selecting children for medical attention. A study of the efficiency of this screening method revealed that eight out of every ten selected children had health problems, whereas in an unselected group such as an entire grade, only four out of ten children had adverse health conditions.



#### STAFF EDUCATION DEMONSTRATION

The methods used to introduce the new procedures developed by the Astoria School Health Study are of special interest. Time and money spent to improve service is wasted unless the new procedures are assimilated by the staff. In general four methods were employed to educate the school health personnel: (1) a training center for supervising school physicians (2) intensive demonstrations in special districts (3) group meetings to discuss the procedures (4) development of a manual of school health procedures.

Following is a brief summary of certain conclusions derived from experience with the task of securing the cooperation of 100 physicians and 600 nurses, when the time arrived to gear the new parts of the program into the school health machinery of the entire city.

After four years' experience with these physicians and nurses, certain principles of staff education have been clarified. For the educator none is original. For the administrator they are significant. For him they are the keys to better service.

1. Adults do learn. By some this is denied. They shake their heads over personnel who have been doing the same procedure the same way for many years, and say that it is hopeless to try to change such a person's habits of thought and methods of work. This is a mistake. It is an assumption which has killed many a promising plan. Adults who are not interested do not learn. But children do not learn either unless their interest is aroused. The interest of an adult whom no leader has tried to stimulate for many years is harder to arouse than the impressionable child. It is equally true that the confidence of the adult must be gained. Again, it is often more difficult to secure the confidence of the adult who, through some unfortunate experience, has learned to mistrust "experimentation." Our experience con-

vinces us that adults do change if the proper stimulus and the right approach are provided.

2. The staff must be recognized as an intelligent professional group. At general meetings and conferences the voiced opinions in the group are welcomed and given courteous consideration. Prompt action is frequently taken on the basis of such proposals. The approach to the staff is not through authority, but through reason. This leads to a third principle which guided the efforts at staff education.

3. Participation is essential to the learning process. It is recognized that many individuals have ideas to express as experienced professional workers about the work. New procedures are introduced as the outcome of group discussion of a problem and the new procedure is brought to the attention of the group as a possible solution. On other occasions large-scale participation of the staff is employed. For example: In order to create an understanding and readiness to accept a complete change in the management of undernourished children, the entire staff of school physicians made a careful study of 5500 malnourished children. Participation, which gives the individual a feeling of authorship in the new policy or procedures, is a most valuable tool in staff education.

4. Time must be allotted for the learning process. Attitudes and ways of procedure cannot be changed without long, hard work by teacher and student. It is time well spent because there is a satisfaction associated with learning new ways which the student carries over to his entire task. It gives fresh vision.

5. The law of change must be recognized. The staff is taught that procedures presented today are subject to change. Moreover, this change should emanate from their own experience with the procedures. The educator's best measure of the effectiveness of his teaching is the ease with which new ideas for

proposed revisions come in from the field.

With this second World War there are already some indications of the beginning of a new era in child health. Efforts to complete the immunization of children against communicable diseases such as smallpox, diphtheria, whooping cough, and typhoid fever are all important because of the shifting of population groups. Plans are being directed towards establishing more facilities for the care of young children both of whose parents are working. With the increased demand for physicians and nurses and dentists by the military, there will certainly be less professional time for school health work. Those of us who have a special interest in the health of the child of school age must study how to make the most effective use of the available time of physician, nurse, and dentist. In this respect, the report of the Astoria School Health Study should be helpful.

Some of the ways of more efficient administration of the service have been discussed here: (1) "streamlining" of record-keeping (2) selection of the children most in need of the school physician's medical examination (3) delegation of certain tests such as height and

weight and vision to the teacher (4) adaptation of the school health examination to meet the needs of the child (5) better planning regarding follow-up of children with health problems. Among methods not discussed here is the fuller use of outside physicians and dentists in the school health program. These are some ways of achieving more effective as well as more economical use of professional time.

To paraphrase a war slogan, "Professional service is precious, don't waste it." And through this searching for ways to conserve may come a finer appreciation of values in health service for the school child. From it may come school health service which integrates more effectively with the entire pediatric program. An era may come which sees full use made of community medical and health services and continuous, well coordinated health supervision from birth to maturity.

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Presented before the N.O.P.H.N. Round Table on Implications of Astoria School Health Study, Biennial Convention, Chicago, Illinois, May 20, 1942.

The picture accompanying this article is by courtesy of "All the Children."

THE CONTRIBUTION which the public health nurse can make to family morale in time of war is well described in a recent letter to M.L.I. nurses by Dr. Donald B. Armstrong, third vice-president of the Metropolitan Life Insurance Company:

Today one of the chief needs in our health program is the prevention of breakdown of morale among parents and children. As public health nurses help patients to face an impending operation, a prolonged convalescence, or the handicaps of some crippling condition, so today they must intensify their efforts to help families with whom they come in contact to face the natural fears that arise as a result of the world conflict. The overanxious person needs to be helped to face the future

with equanimity and understanding. The person unconcerned about what may happen perhaps needs to be a bit more thoughtful of possible emergencies and what he should do. The unaware parent needs to realize that perhaps his children are really quite concerned about this atmosphere of "war."

A public health nurse may be asked questions similar to those implied in the pamphlet entitled "To Parents in Wartime."\* If she is not asked such questions, possibly she should bring them up herself when opportunity presents itself, or perhaps she should create the opportunity . . . The pamphlet is a timely reminder to public health nurses of their responsibility in maintaining the morale of citizens as a contribution to victory . . .

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\*Children in Wartime No. 1, Children's Bureau Publication 282. Superintendent of Documents, Washington, D.C., 1942. 5c.

# The Teacher in the Health Program

By ALICE H. MILLER

A health educator discusses significant implications for the classroom teacher in the Astoria School Health Study

THE Astoria School Health Study holds important implications for the health educator and the classroom teacher. In this discussion, the health educator and the teacher will be considered as one, for while the health educator may have administrative duties as a coordinator, he still has the responsibility for education in health, as does the classroom teacher.

The most significant implication of this study for the teacher is the philosophy upon which it was based—that of thinking, planning, working, and evaluating results together. Its success was due in large part to the fact that all work was done in this manner. School boards, school administrators, and teachers must have a sincere desire to participate in breaking down barriers between groups and professions. This is necessary not only for a better program, but to avoid misunderstanding and overlapping. In the final result the degrees or professions of the health personnel—whether they hold an M.D., B.S., or M.A. degree, R.N., or C.P.H.—do not make a great deal of difference if these persons will sit around the table to discuss the health needs and problems of the school child and determine how each person can best be used for the welfare of the child.

It is futile to waste time in the argument as to who shall administer the school health program—the board of education or the department of health. Cooperation should be the keynote. Administrators and teachers must be more

than just willing to carry out the procedures suggested by the nurse or doctor; they must be willing to give time and attention to working *with* the nurse, the doctor, and others, in helping to plan these procedures. This idea, of course, must work both ways. Teachers have a background of education and experience that should prove invaluable. Where is the school that can carry on a successful health program without jointly determined health policies?

The majority of teachers in the public schools today were schooled in subject matter and how to teach facts to children. Often their responsibilities in the school health program were not included in their training. Therefore, we encounter the attitude, "This is not my job—that's what we have the nurse for." Most teachers are used to telling others what to do. Now, in the light of changing educational methods, they need to learn how to work with and guide children. They must also learn to work with adults. The Astoria School Health Study challenges teachers to be open-minded, to be willing to experiment, and to work with others.

## EVALUATE OUR PROCEDURES

The next implication of the study which teachers should examine is the use of critical evaluation. We have all heard the teacher's theme song: "Yes, that's a fine idea but how in the world can I do more? I'm already worked to death." In many cases the situation may be just that. But if we are to succeed, teachers and administrators must evaluate the school curriculum and mercilessly throw out activities carried on only because of tradition, in order to

make room for those things which are essential to the fourfold development of children—physical, mental, emotional, and social. In the study, a critical evaluation was made of school health service procedures, and needed changes resulted. The same attack can be made on the curriculum to allow time for health instruction and participation in health service procedures.

A more specific implication of the study relates to the teacher's part in the medical examination. The study provided essential criteria for this examination, which may be used as measuring sticks for our own methods. What is the significance of the school medical examination to the teacher? In the Astoria study, she was made to feel that she played an invaluable part in this phase of the program. The premise was that the classroom teacher, through her day-by-day observation of pupils, is in a strategic position to help the physician and nurse. The psychology underlying group planning is most important. It makes the participant feel that this is her program, too, and if it is good or bad, she shares in the credit or blame.

One of the best tools used in this study was the pupil health card. Implications for the use of this record are many. Teachers have objected to health record-keeping, because they often feel that these records are not used, and that their time is merely wasted. Also, when teachers are asked to note their observations of pupils, they may be at a loss to know what to look for and how to record it. The pupil health card lists the factors to be observed and has space for explanation of medical findings, for recommendations on classroom management of the pupil, and for follow-up reports by the physician and nurse based on the school examination. These practical aspects help the teacher understand the health needs of her students.

Too often the teacher does not have access to the health records of children,

or when records are available, the technical or code recordings discourage her. The health record should help teachers to think of health instruction in terms of pupils' needs, interests, and abilities, instead of in terms of health facts. By having close association with the school health examination, the teacher understands it better so that in her teaching she can prepare pupils for it. She can help them appreciate the services of the school physician and nurse; can show the need for a more adequate use of the private physician and dentist; and can do her part in urging correction of defects.

#### WHO SHALL WEIGH AND MEASURE?

Closely related to the school medical examination is the problem of weighing and measuring. Here the study has given the health educator a leg to stand on. How often do we find that weighing and measuring have been done only once during the year because the nurse simply cannot find time more often? How often do we see them hurriedly done while the doctor waits to examine the child? Health educators have stressed the educational value of these procedures to the teacher, but too often the superintendent does not think they are the teacher's responsibility. Or is that the way she wants him to think? Aside from educational reasons, the study gives us common-sense reasons—economic, if you will—for the teacher to carry on weighing and measuring. First, administrators and teachers must be informed as to how the time of physicians and nurses can be spent most profitably. When evaluation is made of all procedures which the physician and nurse, as specially trained individuals, can carry on for the greatest good of children and community, weighing and measuring simply cannot be justified as their responsibility.

The teacher who is interested in child growth and development can use this

procedure as an educational device to encourage the child to live healthfully. She can satisfy her own concern in regard to the growth of the child, and she can secure important information on causes of absences, the pupil's general activity, and his food and sleep habits—all of which enter into the determination of the child's nutritional status. She can then make her findings available to the doctor and nurse.

#### USES OF VISION TESTING

The health educator may well express gratitude to the study for the research done in vision-testing. Here is another procedure that often falls by the wayside because the nurse cannot give it enough time. The study gives us facts which prove that the teacher can correctly screen out pupils. Upon careful checking and rechecking, it was found that of all children with 20/50 or worse visual acuity reported by teachers, 91 percent were correctly reported. The accuracy of the teacher's findings is less reliable for borderline cases—only 66 percent of those found to test 20/40 were correctly reported.\*

The procedures were worked out so that the teacher gave two lists to the nurse. One contained the names of all children having a visual acuity of 20/50 or less and no glasses; the other, those children having a visual acuity of 20/40 and no glasses. The nurse without retesting invited the parents of pupils with a visual acuity of 20/50 or less to visit the school for a conference about the child. If there was no response, a home visit was made. She then retested all children with 20/40 visual acuity, and parent conferences were held in regard to these children. Where there formerly existed divided responsibility, duplication of effort, and neglected cases, there

is now integration of the nurse's and teacher's work, with an understanding by each of her own responsibilities.

As a teacher, I feel that when I test the vision of my class of forty children, I know just a little bit more about each child's visual acuity and behavior; I am just a little more interested in the habits he uses that may affect his eyes; and if he wears glasses, I am a little more concerned about the care he gives them. I may be a little more careful, too, about making adjustments for those with eye difficulties and about observing the conditions in my room that relate to vision. Then, if I'm a good teacher, I'll capitalize upon the vision-testing period by using it to interest pupils in a study of the care of the eyes and the value of the school vision program. In this way, I shall be coordinating my classroom teaching with the school health services. Not the least of the good results is the conservation of the nurse's time so that she may have more parent conferences to carry on effective follow-up procedures. One way to measure our success is to find out whether each year we are getting an appreciable increase in the number of parents and children who are visiting their doctors and dentists; and an increase in the families learning to depend upon themselves for achieving and maintaining good health. Many of these results depend upon health education.

#### CONFERENCES ARE HELPFUL

Another procedure which has important implications for the teacher is the teacher-nurse classroom conference. Examples can always be cited of the nurse whose visit to the classroom is used for an isolated talk on hygiene to the children and as a recess period for the teacher. To these may be added the nurse who visits the classroom to tell the teacher about health examination findings, thus requiring the teacher to have one eye and ear cocked on her students while

\*Nyswander, Dorothy B. *Solving School Health Problems; The Astoria Demonstration Study*. The Commonwealth Fund, New York, 1942, page 159.



she talks. This type of conference is naturally unsatisfactory to both. The Astoria plan is to have a conference period of 40 to 45 minutes for the nurse and teacher once or twice a year, arranged in advance, which gives the teacher a chance to become informed about the nurse's follow-up progress. It also provides a means of selecting children for medical attention. Through this type of conference, the teacher gets better acquainted with the nurse and can ask her for scientific materials for classroom instruction. She can have a leisurely discussion about certain pupils who appear to have unusual health problems. Any questions that pertain to the health service procedures can be answered in this conference, too.

For example, it was found that in one school, 79 children from six grades had obtained glasses. The average interval between detection and correction of the defect increased from 10 months for children in the second grade, to 29 months for those in the eighth grade. Further study of the records showed that only half of the medical cards for these 79 children contained any data on vision. In no single instance, on either the medical or the class card, were there statements as to the conditions under which the glasses should be worn, when the child should have them rechecked, or whether the glasses were satisfactory. In planning for correction of these weaknesses, new emphasis was introduced into the nurse-teacher conference to stress the importance of teaching children how to care for their glasses and the necessity for having them rechecked.

Both administrators and teachers should easily see the value of this type of conference in contrast to the catch-as-catch-can method. And this plan avoids the old habit of using the nurse for incidental classroom health teaching, because in the teacher's words, "You know so much more about this than I do." It should establish the fact that the nurse

can best be used as a teacher of teachers, who in turn have the responsibility of classroom instruction.

#### IN-SERVICE TRAINING PRINCIPLES

The in-service training program of the study is of special interest to teachers. Many of the principles used in the study can be applied to meet the needs of our teachers. First of all we must be absolutely frank in facing our needs. The majority of teachers and school administrators now in service will be retained. Relatively few of these have had adequate training in health education and in child growth and development. During this war, many of our doctors and nurses will be taken into service. Teachers must therefore be trained to carry on many procedures not previously done by them. Our problem, then, is one of in-service as well as pre-service training.

A good starting point is to let the in-service training program evolve from the sessions of the school planning committee. While the members of the committee actively engaged in the school health program are discussing plans, determining policies, and delegating duties, teacher needs in the light of these decisions will become evident. For example, if the teacher is to become efficient in the daily observation of her pupils, she must be trained to do so and must have the guidance of the physician and nurse. To learn the proper techniques of vision-testing, she needs to be taught by specially trained persons. To make certain that the subject matter she uses in classroom health instruction is scientifically correct, the teacher must have the help of the doctor and the nurse, who should be active members of the school curriculum committee.

This idea of using the doctor and nurse as consultants to the teacher whenever she needs help becomes a part of her learning. The teacher should read the journals and books of the nursing profession, and the nurse should keep

abreast of the newest educational trends. In this way both will have a better understanding and appreciation of the school health program and time will be saved in committee meetings. Much progress has been made where teachers have been invited to visit well baby conferences, dental clinics, and other health activities, and where the nurse has been made to feel welcome as a visitor in the classroom. The nurse can serve as an excellent interpreter of community health resources to the teacher, since both are interested in guiding children and parents to proper sources for health protection.

When one considers the whole school

health program, he realizes that it is difficult to dissect and discuss the various divisions separately, because of their interrelatedness. This fact shows again the need for group thinking, planning, and working, in order for the parts to function as a whole. It shows again the imminent need for breaking down the barriers between groups and professions in this field and it definitely challenges us to get rid of the patchwork type of school health programs we have been carrying on.

Presented before the N.O.P.H.N. Round Table on Implications of Astoria School Health Study, Biennial Convention, Chicago, Illinois, May 20, 1942.

### AN IMPROVISED CRIB



Canvas, box-shaped



with straps slipped over chair ends



makes secure baby bed

A USEFUL and inexpensive crib can be made of canvas attached to two chairs by straps of double thickness as illustrated in the pictures. This crib costs about 50 cents and is easier to handle than the frequently used laundry basket. A mattress of folded blankets,

quilts, or straw is used. A variation of the canvas crib is one recently demonstrated at a Red Cross Home Nursing institute, made with double ends of cretonne fitting over both chairs.

CAROLINE E. KIDDER, R.N.  
Grant, Alabama

# Records Are Essential

By ROBINA KNEEBONE, R.N.

Records are an important tool for developing a school health service which is a vital part of the community health program

**R**ECORDS ARE essential to evaluating and understanding public health situations. Today, school health is a vital part of public health, and careful record keeping and evaluation by the school nurse are an important measure of community health. There is no better time than the present for greater perfection in keeping more significant case histories and in making more careful annual summaries of the work of the school health program.

A review of the values and processes in record keeping is timely now as the school year with its rush of extra work begins. Moreover, when a new school nurse is just commencing her task, the records of her predecessor will be of great help to her in picking up where the former left off.

Record keeping may be approached in several ways. Objectives, methods, and relationships reflected in the records are all vital aspects.

Some objectives of record keeping are: (1) to provide as complete a health history as possible for each child (2) to obtain statistical information (3) to guide the nurse and authorities in judging the effectiveness of the whole program and determining emphasis for future efforts (4) to meet local, state, and national record requirements, and (5) to note and evaluate changes in community conditions.

Suggestions for improving your records are offered here:

Provide yourself with a complete set of all the health forms required for dif-

ferent purposes by your local authorities, your state health department, and the federal health services. Study these forms carefully so that you may understand the relationship of your own program to the local, state, or national health program. Know the information that other local agencies may require from you in order to help provide a truly co-operative community health service. School nursing is never an isolated service, but always part of the entire community health program.

Accuracy and conciseness are essential. In narrative records, quote the exact words of the patient or family in instances where their expressions are an index of their social patterns, beliefs, traditions, or other unique characteristics.

Each space on the record form should be filled out or a reason given why requested information is not included. Ink survives better than pencil for permanent records. Typing or printing is more easily read than writing. Keep plenty of blank records on hand.

Availability of records is desirable. As soon as possible after the event the record should be available for use. File in a central, easily accessible place. They should be ready on time and sent to the right person and place. It should be easy to locate records about an individual, family, or school. Records filed alphabetically by names of individuals or families, with the district carefully noted, save the nurse's time. Duplicate copies of records or notices sent to parent and teacher should be kept. If extra copies are needed, make them when the *first* recording is made.

Find out the state department of

health and local policies in regard to destroying records.

Translate your statistical records into interesting graphs, pin maps, or statements, and use them to interpret the service to the school officers and teachers, parent-teacher associations, the local nursing association, and other interested groups.

Employ labor-saving devices such as different colored cards, tabs, and tags to facilitate prompt recognition of records.

#### RELATIONSHIPS

As school health programs assume greater community significance, the work of the school nurse will be extended into a broader sphere of human relationships. These her records should reflect.

Relationships to consider are those:

1. *With the child.* Develop in the child an appreciation of the value of the data that are being recorded. Acquaint the child with the reason for the record, the place it is kept, and the satisfaction to be experienced by him in a recording of good health facts. Encourage the child to desire improvement in himself and assure him that this will become part of his health history.

2. *With the parents.* Acquaint the parents with what is recorded, the particular improvement sought, and the fact that accomplishments will be noted on the record. Assure them that records are confidential. Encourage parents to ask to see their children's records and to learn to understand the doctor's and nurse's notes. Promote a co-operative relationship and understanding between the school health personnel, parents, and family physician, all of whom are working to improve the child's health.

3. *With the teacher.* Make records of pupils, especially new pupils, so accessible to the teacher that she will feel a desire to know the entire health

history of her pupils and will experience a feeling of loss when records do not exist, are incomplete, or not available. Teachers should be encouraged to report observations to the nurse which the nurse may record as "teacher observations." The teacher will be more alert to vision or hearing defects, poor muscular co-ordination, and child and family attitudes if she knows that her observations are valued.

4. *With the school physician.* Records that are ready, accurate, and complete will aid him in making judgments. He will get to know the child, the family, and the nurse through the medium of the records. The record is not a substitute for knowing the child or home, but it helps in interpreting the present condition in the light of the past history.

5. *With the family physician.* The family physician should be encouraged to share necessary records with teachers and principals in order to safeguard the family, promote common understanding, and assist in furthering the child's health progress.

6. *With the dentist.* The record should include available information on the state of the child's teeth. Dentists appreciate the recognition of their observations and recommendations. Often the past care or plans for a child's future dental care are significant.

7. *With the community.* The summary of records furnishes a balance sheet which will show the community what the school health program has accomplished.

The community effectiveness of a school health program is its real value. The school nurse by her sincerity of purpose, industry, clear vision, and repeated evaluations can make a tangible contribution to the health of the children of her community, an accomplishment to be regarded with respect in time of war as in time of peace.

# Official Agency Supervises School Nurses

By RUTH N. NELSON, R.N.

Supervision of school nursing as part of the generalized service of a county health department is described here by a supervising nurse in an official agency

**I**N NASSAU County, Long Island, New York, with a population of over 430,000, school nursing is administered under three different plans. In 157 of the county's 170 public and parochial schools, service is rendered by 70 school nurse-teachers employed by the Board of Education, with nursing supervision from the State Department of Education at Albany. Two small visiting nursing associations contract for service in 7 of these. In the remaining 13, nursing is provided by the County Department of Health, in accordance with the policy of the New York State Department of Health which places this responsibility on county health departments where school boards and trustees are not able to support school nurse-teachers.

The program for supervision of school nursing of the Nassau County Department of Health is described here. The Division of Public Health Nursing consists of a director, 3 supervisors, and 33 area nurses. Through the integration of services with those of 4 nonofficial agencies, the total number of nurses carrying on a generalized service is brought to 40, with 5 supervisors.

In the supervision of school work as a part of a generalized service in an official agency, application of the general principles of supervision with which we are familiar does not differ from that in other services. The policies and specific activities agreed upon by the administrative heads of the health agency

and the school determine how the supervisor shall function in helping the nurse improve the quality and test the effectiveness of her service.

This implies that agency, supervisor, and nurse are all aware of the philosophies of school administration, respect them, and function as a part of the school system while rendering service within the school plant.

## BEGINNING NEW PROGRAM

Upon assumption of responsibility for the nursing service in a given school, the supervisor assists the nurse in planning for conferences with school personnel to define clearly the responsibilities of each participant, and agree upon the details of a work plan. Once the plan is accepted the supervisor helps the nurse organize her work in the school so that emphasis will be placed where it is needed most for maximum benefit.

The supervisor further guides the nurse in fusing her school activities with those of her other community services, continuously pointing out the inter-relationships which condition satisfactory functioning of school, home, and community in order to safeguard the health of the child.

Because of the variety of service demands, such as tuberculosis, syphilis, cancer, and maternity, a most important function of the supervisor is to help each nurse analyze and balance her work according to the needs of her particular area. For example, a nurse serving one



or more schools cannot be expected to render as much clinic service as a nurse working in an area where there is no school work.

In another area where illness incidence including acute communicable disease is high the supervisor helps the nurse discriminate, in both home visiting and school activities, between the immediate and essential work to be done and that which can be planned for the future.

#### GENERALIZED NURSE IN SCHOOL

The function and activities of the generalized nurse carrying on a school program necessarily differ from those of the school nurse-teacher who spends her entire time in the school. The generalized nurse must emphasize group conferences with teachers to instruct them in the observation, screening, and testing of children, thereby placing more responsibility on the teacher for continuous observation of the health status of children. The supervisor, therefore, must stimulate the nurse to keep abreast with scientific knowledge necessary to assist teachers in selecting and utilizing teaching materials and to improve their methods. The supervisor must assist the nurse with the preparation of group talks, and must herself share this responsibility when by so doing she can strengthen the work of the nurse. When the children who have been screened, or referred by the teacher, come to the nurse, it is most important that this experience have educational value for the child. It is incumbent upon the supervisor to help the nurse be aware of and use such opportunities.

#### SCHOOL NURSE AND HOME VISITING

There is no more important function of the school nurse than the home visit to interpret the health needs of the child. Such home visits by the health department nurse are enriched by her concept of family health service and her latitude in dealing with the school child's health in relation to the health needs

of the entire family. For example, one nurse relates:

A home visit was made to an eight-year-old child, Robert M——, who had frequently been absent from school due to colds.

During the visit, I met the father, a 42-year-old, emaciated man who had had tuberculosis about ten years ago. He had not reported to his physician for x-ray for two or three years. I noticed he coughed and expectorated into a handkerchief which he put back in his pocket. He did not have faith in doctors and felt it was better to stay away from them. The mother, a telephone operator, was of little help, for she thought her husband was neurotic. He would get over the cough; she did not believe in looking for trouble.

An hour was spent with the family, explaining the danger of guessing at the condition of a person's health. The mother showed great concern about the children and was willing to have them x-rayed as soon as arrangements could be made. The great importance of her own health to the family group was stressed.

The end result was: (1) Mr. M—— was x-rayed and admitted to the county sanatorium. (2) All family contacts were examined and admitted to nursing service for supervision. (3) Health supervision resulted in fewer school absences for Robert.

It is through such reports that the supervisor may diagnose the needs of the nurse in regard to her home visits and test the effectiveness of previous guidance.

The real test of whether or not supervision is functioning properly is to be found in the degree of development, analysis, and self-direction demonstrated in the work of the nurse. For example, one nurse writes:

It was my experience in doing school work this summer to be told by three mothers that their children refused to

visit a dentist, although the mothers themselves understood the need and wanted the children to go. One boy was forced against his will and bit the dentist's finger. This impressed upon me the close relationship of our home instruction in regard to child training and the health problems of the school child. This phase of our health supervision is, I think, more difficult than that dealing with physical health. I shall try to improve my school work by giving more and better instruction in regard to home training and guidance of the child of preschool age, and more health guidance to the children in school.

While this discussion is chiefly concerned with school nursing in the Nassau County Department of Health, it

would not be complete without reference to the fact that supervision is also concerned with correlating this work with the work of nurses in areas where school nursing is a function of the board of education and the nonofficial agency. The total functioning of school nursing under these various administrative plans in Nassau County is facilitated by the existence of a public health nursing council in which lay and nurse representatives of all organizations rendering nursing service gather to discuss public health nursing problems.

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Presented before the N.O.P.H.N. Round Table on Supervision in School Nursing, Biennial Convention, Chicago, Illinois, May 20, 1942.



## TEACHING MATERIALS FOR NURSES' CLASSES

A METHOD of making our own chart materials for nurses' classes at very little cost has been devised because of the lack of funds for purchasing anatomy charts and models, and the inability to purchase many of them which are made in Germany and Japan.

Illustrations from small books can be photographed in black and white or color, by using a good 35 mm. camera and a copying lens. The picture can then be projected as large as is desired on a screen, by printing the positive film, mounting it in a 2 x 2 inch slide holder of pasteboard or glass, and showing it in a projector. A class can then study the picture as though it were a regular chart. Some of the anatomy pictures projected in this way seem to

be even more clear in outline and detail than in the book, since they have a depth that a flat chart does not have.

Nursing procedures and setups, useful in teaching home delivery procedures to small groups of midwives and nurses, have also been photographed.

If one has photography for a hobby, the pictures cost comparatively little. The total cost of the black and white slides, including the film and the developing and printing, is a little over 11 cents; of the colored slides, 8 cents. A projector may be purchased for as little as \$7.75.

ELIZABETH R. FERGUSON, R.N.

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# Supervision of School Nursing by a V.N.A.

By HELEN V. STEVENS, R.N.

**A nonofficial nursing agency offering a general family health service carries on school nursing in areas where there is no other provision for a school health program**

**I**N PENNSYLVANIA, local school health provisions follow the general pattern of public school administration in the state, being divided into first, second, third, and fourth class school districts. In the first three classes, medical inspectors and nurses for schools are appointed and paid by local school authorities. Pittsburgh is the only first class school district in Allegheny County, and the responsibility for its health program rests jointly with the Board of Public Education and the City Department of Public Health. To prevent duplication of the personnel dealing with the health of the school children, an arrangement has been made whereby the two departments jointly employ the same staff of physicians and nurses. For the second, third, and fourth class districts, the State Department of Public Instruction grants subsidies for certified nurses. The fourth class districts are served to a limited extent by local physicians and by state nurses who are appointed, paid, and directed by the State Department of Health.

School health work in Allegheny County outside Pittsburgh is quite uneven, varying from a complete medical, nursing, dental, and health instruction program in the one city of the second class, and from well-organized programs in one third class city and one of the larger boroughs, to lack of even an annual examination in many of the fourth class districts. In the third class districts medical inspection is fairly complete, but over half lack the fully as

important nursing service. Limitation of facilities for the correction of physical defects is a general handicap.

## RICH AND VARIED REGION

Allegheny County itself is an area of striking contrasts with its vast industrial concentration and dense urban conditions in and around Pittsburgh, not far from luxurious residential suburbs, while much of the county remains rural and in some sections distinctly backward. The school buildings typify this contrast. Some are ultra-modern with electric eye doors and similar equipment. Almost next door are primitive one-room school-houses where the only provisions for hand-washing are the bucket, dipper, and basin, and these meager provisions are maintained only when there is an ever-watchful school nurse. It has been said that the hills and ravines of Allegheny County have given to its various boroughs and townships the diversity and local independence and pride that makes each community a unique unit. Others claim these strong independent characteristics are due to the temperament of the early Scotch-Irish settlers. Be that as it may, each community must be approached with respect to itself alone and not as just one of many.

The service of The Public Health Nursing Association is extended to Pittsburgh and all of Allegheny County, an area of 725 square miles with a population of one and one-half million. The program is a generalized family health service. School nursing is included in



The school child cannot be considered apart from his home and community

the county districts when a local group will sponsor and help finance it, when it is a consistent part of the community program, and when the number of school children can be supervised without disadvantage to the other services—particularly morbidity and maternity.

#### SCHOOL CHILD HEALTH

We all accept the fact that there is no essential difference between the health of the child at school and at home, and consequently the supervision of his health routine at both places is recognized as of importance to good health in the future life of the child. School health work opens up the practical possibility of continuous oversight for at least ten years of his life, and gives an opportunity for health teaching not only of the child but of parents, teacher, and community as well. It provides the mechanism for detecting and preventing the spread of communicable diseases and, of course, for correction of

remedial defects. School health work makes for wider contact with the families of a community. For all these reasons, school service contributes to a program of family health service by making it more comprehensive and complete. In the light of our experience, we would say that school nursing as a part of our general program in county communities has been of reciprocal advantage to all branches of our service. I recently asked a group of county nurses why they were as enthusiastic as they are about school nursing as a part of their generalized programs, and some of the replies were:

I think that both parents and their children like the idea of knowing only one nurse instead of two, who will come into their homes to give care and who will discuss school problems at the same time. The parents seem to confide in the nurse and talk to her more freely than they would if she were making only infrequent visits.

School work and home visits help the nurse learn her district better. Many families living in out-of-the-way places would never be seen

if it weren't for the fact that some of the children in the family attend school and follow-up home visits have to be made to their parents. Then, too, the nurse is sometimes able to bring back to the teacher information about a child's home conditions which helps the teacher to understand the child and further his progress in school more effectively.

School field visits provide an opportunity for entering the homes when conditions are relatively normal, whereas otherwise we come only when a member of the household is seriously ill. This is of invaluable aid to us in studying other members of the family, and affords advantage for earlier and better preventive teaching.

In making school field visits, a complete health visit can be made—including the whole family as well as the school child, and many times help can be given in wiser planning of economical meals, so that the nutrition of the entire family can be improved. Furthermore, the school field visit is frequently the family's first introduction to public health nursing services.

The public health nurse who is not doing school nursing could hardly be as aware of the ramifications of the health problems of the school child as the one who is doing school nursing. On the other hand, the school nurse who would not be carrying the generalized program could not make use of all the opportunities to teach health that she finds in her numerous family contacts. It is most gratifying not to have to break down into artificial categories the public health needs of a community.

At the present time, 12 of our staff nurses in the county districts are doing part-time school nursing, serving 56 public and parochial schools with a total school population of 13,500. In some instances, the school nursing service includes both public and parochial schools; in other cases, where the public school has a school nurse, our service is extended to the parochial school to complete the community program.

The nurses for these county districts are selected after at least one year on the city staff from among those who have demonstrated initiative, self-reliance, good judgment, and teaching ability, and who are able to drive a car in all seasons

over all kinds of roads. Personality, as always, is a determining factor. The majority of the nurses have had post-graduate work in public health nursing or are currently taking courses at one of the local universities. For the most part, they have not had any school nursing experience, nor any experience in being identified with a particular community as "our nurse." In every instance there is an active local committee with which the nurse works closely and this, too, is a brand new experience. So not only must the details of school health supervision be learned, but also there is this transition from the relative anonymity of the larger general staff to the more conspicuous and personal role the nurse must now assume.

#### NURSE AND SUPERVISOR

When the staff nurse reports to the county supervisor she is given a careful introduction to her new territory with particular emphasis on school nursing and the rural or suburban situation. She has regularly spaced conferences with the supervisor and demonstrations by the supervisor of classroom inspection and vision testing in the school. Later the nurse is observed in these procedures. A continuous staff education program is carried on. Once each month the entire staff of nurses working in the county get together and present an educational program emphasizing their own particular needs.

The County Manual, a supplement to the nursing manual used by the entire staff, summarizes briefly public health nursing in the suburban or rural situation in contrast to that in the urban situation, and assists the nurse in maintaining a uniform standard of work adhering to the policies and procedures of the Association. A line diagram illustrates her relationship to the nursing committee and to the State Department of Health. Problems more or less peculiar to the nurse working in a suburban or



rural community are discussed, and policies enunciated. The Association's library is easily accessible for her further education.

In these ways a nurse is introduced to the school health field. Supervision of the nurse is a continuous process and follows the principles of supervision enunciated in the Supervisor's Manual of the Association. Prior to the first week of the school term, the staff nurse being introduced to the school health program confers with her supervisor. Points for discussion include: (1) how the school nurse acts as a connecting link between the school and the home (2) routine procedures such as classroom inspections, vision testing, assisting the school physician, if there is one, in doing periodic physical examinations (3) giving health talks (4) first-aid treatment which she will be expected to carry on, and (5) how the teachers integrate health instruction into the curriculum. Also discussed is (6) the subject of home visiting for correction of defects, and how these school visits fit into the entire program of the organization. Her time schedule for service in the various schools in her district is worked out.

#### DAILY WORK ROUTINE

The nurse's daily plan of work usually designates the first hour to be spent in one of her schools. If she has five schools to cover, then each morning of the week she reports at a different school. The schools, her supervisor, and likewise the parents, all know what day to expect her at their school. This makes it possible for parents to plan conferences with the nurse. To keep this schedule it is sometimes necessary for the supervisor to relieve her of some of her community nursing work. On the other hand, if the latter is not heavy, the nurse can remain in the school an additional hour for special activities there such as a group of vision tests. The remainder of her day is spent doing bedside nursing

and instructive work in the homes. General nursing calls take precedence over school field visits or visits requested by the teacher because of special behavior problems. As the nurse learns to know her pupils, school field visits can often be made between nursing visits when she is in the neighborhood where the child lives. Many times, in school field visiting, the nurse finds antepartum patients, preschool children in need of medical supervision, or mothers who need help in planning adequate diets or budgeting.

Special activities—such as a tuberculin testing program or a Beginners' Day program—are planned in minute detail by the supervisor and nurse, after which the nurse bears the major responsibility for enlisting the co-operation of all concerned and carrying out the plans. At the present time home nursing classes under the Red Cross are being given by all the school nurses.

Like the nurses working within the city of Pittsburgh, those in the county areas also have access to the help of the special consultants on the staff of The Public Health Nursing Association of Pittsburgh. The mental hygiene consultant is available to help the nurse in dealing with behavior problems, and the maternity, child health, nutrition, tuberculosis, and social hygiene consultants in dealing with problems in their respective fields.

#### SCHOOL NURSING SIGNIFICANCE

In conclusion, I wish to point out how the events of today emphasize most vividly and dramatically the importance of the work of the school nurse. Among the young men who are being found physically unfit to fight for their country in this crisis, how many are suffering from long-standing defects which were present but not discovered when they were in school? In how many other cases was a nurse aware of defects but unsuccessful in persuading parents to take the needed corrective measures?

On the other hand, look at the school nurses who are justly proud as they see the effectiveness of their work confirmed by the physicians who examine and approve for military service many boys who were under these same nurses' supervision during their school life. In these youths we see the beneficial results of the co-operation of doctor, nurse, teach-

er, parents, and the whole community who realized long ago that the good health of their children and their nation requires that everyone work together toward this end.

Presented before the Round Table on Supervision in School Nursing, Biennial Convention, Chicago, Illinois, May 20, 1942.

Picture is by courtesy of "All the Children."



## QUIZZING THE EXPERTS

**M**ONTHLY STAFF education programs for all personnel of the Indiana State Board of Health were sponsored by the Bureau of Health and Physical Education during 1941. Each bureau chief was asked to present the activities of his bureau in any way informative to the employees of the Board—including secretaries, janitors, nurses, physicians, statisticians, engineers, and others. The program could not be too technical, but had to tell the story of the bureau.

The nurses in the Bureau of Public Health Nursing decided that the program would have to be humorous and provocative in order to keep the audience awake at 5:00 p. m., and that radio quiz programs offered an idea. A large sign "Take or Leave It" adorned the stage so the group would get the idea at once. Ten persons were selected for the platform in a somewhat sub rosa manner in order to have participants who would co-operate on the humor angle as well as furnish a diversified group. The commissary proprietor offered milk in place of dollars for the correct answers. The day was hot and the milk cold, so

the reward was an inducement to try for the right answers.

A large blackboard was used and the questions were grouped under the following major headings for the participants to choose from:

1. Specialty (if any) and territory of each member of the Bureau of Public Health Nursing.
2. Sanitation
3. Administration
4. Maternal and child health
5. Communicable disease, including tuberculosis, syphilis, and gonorrhea
6. Vital statistics

Some of the questions asked were:

1. Consultant nurses in the Bureau of Public Health Nursing give consultant service to school nurses. *True.*
2. It is not necessary for an expectant mother to visit the physician if the public health nurse gives nursing supervision. *False.*
3. Maternal and infant death rates might be reduced if nurses gave assistance to the doctor at the time of delivery. *True.*
4. Most public health nurses in Indiana assist the physician with deliveries in the home. *False.*
5. Public health nurses advise mothers to have their babies vaccinated against smallpox before one year of age. *True.*

# The College Nurse in the War Effort

By FERN A. GOULDING, R.N.

THE COLLEGE campus, like every other phase of American life, has undergone many changes during the past few months. Our American colleges carry grave responsibilities in this war crisis, and every college administrator is confronted with difficult problems in the execution of new assignments incident to the war effort. Four of these problems have a direct effect upon the work of the college nurse. First, educational institutions must speed up their production of trained men and women just as industry is speeding up the production of war materials. The college faculty and service personnel must work faster and longer hours to meet the urgent demands for trained war workers. Many colleges are already operating on a twelve-months' program, and others will adopt a similar schedule this summer or fall. All college personnel will be affected by this change, and the college nurse must cooperate to the fullest extent with this new program. She must be even more vigilant in health protection so that this accelerated program may not be interrupted by preventable illness.

Second, many of the state universities and technical schools will be used as training centers for trainees from the armed forces. The addition of hundreds of young men to these colleges every few weeks will present problems of housing, feeding, instruction, medical and nursing care, and hospitalization. Many adjustments will have to be made in the routines of those departments concerned with the care and training of service groups. The college medical and nursing services will play an important role also in the task of health maintenance of these temporary residents.

Third, it is increasingly obvious that the many obligations of the American colleges will have to be met successfully with a markedly reduced personnel. All teaching and service departments will be understaffed because of the entrance of staff members into war service. In some of the smaller departments, such as the college health service, this loss of personnel will work severe hardships, because substitutes will be less easily obtained than in other departments. Many college physicians and nurses are responding to the urgent call for war service, and those remaining in college positions will have to carry on to the best of their ability and strength. They will, however, be making important contributions to the total war effort, in helping to maintain the good health of young, potential war workers and civilian leaders. The prevention of incipient epidemics among these young people is of major importance.

Fourth, all colleges will probably suffer financial reverses during the war. These reverses will be inevitable because they will be concomitant with business reverses, the high costs of war, and reduced income due to low student enrollment. Reorganization and retrenchment will be necessary, and the college health service will survive, in many instances, only if it has proved its essential value during this war crisis. College physicians and nurses must recognize the probability of budget reductions, and must take immediate steps for conservation in every way, through judicious use of materials, time, and energy, so that major health activities may be continued even if programs are restricted.

These problems are a few of those that confront the college administrator,

and suggest some of the factors that will affect the work of the college nurse during the next few years. Because of the exigencies of the war program, every loyal college nurse will cooperate with the college administration in its effort to fulfill obligations to the student, the state, and the nation.

Each institution has its own peculiar problems, but there seem to be five major methods by which the college nurse may assist in the college and the national war program. The following suggestions are offered in an effort to give some assistance to college nurses who are faced with the problem of assuming new duties incident to the war effort.

#### REAPPRAISE HEALTH SERVICE

Some time must first be spent in an over-all review of the present college health program, with a view to "streamlining" present activities. This review can best be made by a committee of appreciative and understanding members of the college staff, in conjunction with a medical committee. Members of this committee should be familiar with the entire college situation in order to appraise the health service objectively.

In any service certain routines are continued long after they have outgrown their usefulness, and some are duplicated by other staff personnel. All non-essentials and duplication of effort must now be eliminated. Objectives must be determined, and ways and means created whereby they may be attained. In plans for effective health service, cognizance must be taken of probable peak loads of nursing care that occur on every college campus, with accompanying fatigue of the medical and nursing staff members. At such times, it is only possible to care for the acutely ill, and regular routines should be so staggered that they are carried out when the sick load is likely to be at the minimum. With the determination of objectives that are most impor-

tant and concentration of effort on selected services, the health staff will more nearly accomplish the demands of the job before them. It will be far better to limit the health program to the most essential items and do them well, than to scatter one's energies over such a broad area that before the year is over, fatigue and added duties prohibit completion of the program attempted.

#### STRESS PREVENTIVE PROGRAM

In the determination of objectives for the health service one must be careful not to substitute some of the more dramatic activities for the long-time, proven services. For instance, it is always necessary to care for incipient health hazards, and it is vital in these critical times to prevent epidemics that would demoralize the educational and war-training programs. Students must be encouraged more than ever to attend the clinic for the care of minor illnesses, and in the event of communicable diseases isolation must be strictly enforced.

By the same token, a broad immunization program should be initiated early in the fall. An intensive program of Mantoux testing and x-ray follow-up should be maintained for the early detection and care of incipient tuberculosis. Through classroom education and local newspaper publicity each student must be taught that it is unpatriotic to permit himself, by neglect, to become the source of an epidemic during these critical times. Student cooperation in the administration of an essential health service must be solicited.

#### USE AUXILIARY WORKERS

In most colleges auxiliary workers, both men and women, may be recruited from the student body. In some instances they may be given a small remuneration, or if necessary because of limited budget, they may be asked to work gratuitously as a contribution to the college defense program.

The students selected for this service

should be very carefully chosen, and should be given 12 to 15 hours of training before they are allowed to serve as hospital and clinic helpers. Experience has shown that these auxiliary workers make splendid nurse assistants. Students can be trained to do work such as simple bedmaking, cleaning unoccupied rooms, giving morning and evening care to convalescents, and serving trays at mealtime. Women students' work should be confined to the care of women patients, and men students should give bed care only to men. Student auxiliaries should not be allowed to enter rooms of patients suffering from communicable diseases, but other services which they can render will release the nurse to give this more highly specialized care herself.

Students may be trained to assist in the clinic, and are capable of helping with such duties as making dressings and keeping supplies on hand and in order. They can also assist with routine records, and other clerical and stenographic services.

In the selection of student auxiliaries, certain personality characteristics must be considered. The student must be in excellent health, and must be fundamentally interested in this type of service. No student should be encouraged to do the work merely through patriotic zeal, and those who seem to be motivated by morbid curiosity should be discouraged. The student must know how to take orders from those in charge and must be dependable. He must recognize where his job ends and where the professionally trained worker must assume charge. The student must be willing and able to work hard when on duty. An auxiliary worker must never become partner to gossip regarding hospital or clinic affairs.

A training period to prepare a few good students for this auxiliary work early in the fall term would assure the help of additional personnel when sickness is more prevalent. Students re-

cruited from Red Cross home nursing classes—who also meet other requirements—would probably fit well into this program because of their interest and training. Additional training must be given, however, because the home nursing course does not prepare them for this type of work and should not be used for this purpose. There are always students who welcome the opportunity to serve, and the college health service can benefit by their help, both in usual duties and in the event of epidemic or disaster.

Students who volunteer for auxiliary service should be told that the 12 or 15 hours of instruction which they receive will not qualify them to be Red Cross Volunteer Nurse's Aides, which requires much longer and more detailed training. The usual college hospital is not equipped to give such training.

#### HOME NURSING AND FIRST AID

Although it will be extremely difficult for the college nurse to add teaching duties to an already overloaded program, it seems imperative that she should assume responsibility for teaching home nursing to her campus groups. Because of the serious local shortage of professional nurses in every community, more women must be trained to give care to sick members of their families. College girls should be prepared for this service, and the college nurse is the logical person to undertake this teaching. If at all possible, faculty women, faculty wives, and other townswomen should be invited into these classes, and some of them will gladly act as assistants in subsequent classes.

It is essential also that first-aid courses be taught, and the college nurse may have to initiate this program. She may find it necessary to teach a few standard and advanced courses and arrange with the Red Cross for the training and subsequent authorization of several instructors among other college per-



sonnel, in order to maintain a continuous first-aid program on the campus.

Unlike courses in home nursing, first-aid classes may be taught by properly trained and authorized nonprofessional persons. Thus the burden of first-aid instruction need not be carried entirely by the college nurse. It is most desirable, however, for the college nurse to prepare herself to teach first aid, to render possible emergency care to the injured, and to direct the organization of first-aid units in the event of war disaster. Every campus, like every other civilian community, must be prepared for disaster relief.

#### RECRUITING STUDENT NURSES

The college nurse is in an enviable position to aid in the national program for the recruitment of nurses. Every college nurse should obtain from her State Committee on Recruitment of Student Nurses the up-to-date facts concerning the national and state programs for recruitment and preparation of nurses, for students who are interested. Through information furnished by the nurse to the local newspaper or presented through talks to groups on the campus, students may become interested in the three-year basic nursing course or the five-year combination program which leads to the college degree and nursing diploma.

In giving vocational information concerning nursing education, no effort should be made to divert students who have already determined upon their major academic goal. In every college, however, certain students are undecided in regard to their professional future. Others are attending college for a couple of years until they reach the minimum age for entrance into a school of nursing. Many girls also declare that they "always wanted to be a nurse," but have heretofore met with parental opposition because of inadequate understanding of the duties and opportunities of the profession. The college nurse is in a splendid position to encourage qualified young women to become nurses, and the college trained woman, if she is acceptable in personality characteristics and adaptability, has a great deal to contribute to the nursing profession.

In conclusion, it may be said that if the college nurse carries her many duties successfully, she is definitely making a worthwhile contribution to the total war effort. The nurse who is privileged to work with young college people has the serious responsibility of helping to keep them physically fit for war service, and for the important peacetime tasks that will come later.

Presented before the N.O.P.H.N. Round Table on College Nursing, Biennial Convention, Chicago, Illinois, May 19, 1942.

#### THE AMERICAN JOURNAL OF NURSING FOR SEPTEMBER

The Tuberculous Registrant.....	Corliss J. Williams, R.N.
Burns and Their Treatment.....	Vinton E. Siler, M.D.
Burns and Nursing Care.....	Elgie M. Wallinger, R.N.
All Things to All People.....	Helen C. Manzer, R.N., Ph.D.
Disaster Nursing.....	Ella B. Gimmetstad, R.N.
Converting Hotel to Naval Hospital.....	Gertrude Rudolph, R.N., and Edith Williams, R.N.
Iowa Plans for Home Nursing.....	Eva Woerth, R.N.
Purpura Hemorrhagica—Medical Aspects.....	Charles H. Watkins, M.D.
Purpura Hemorrhagica—Nursing Care.....	Myrl I. Peterson, R.N.
A Maternity Center That Grew.....	Margaret Hogan, R.N.
New York's Practical Nurse Program.....	Josephine F. Goldsmith, R.N.
My Visit to England.....	Virginia M. Dunbar, R.N.
Marriage—Patriotism—Nursing	
Are You Interested in Children?.....	Isabelle M. Jordan, R.N.

# Red Cross Home Nursing Committees

By CATHERINE H. COLLE, R.N.

**T**ODAY, throughout the country, Red Cross chapters are faced with the challenge of meeting the demands of defense-minded people who want instruction in safeguarding the health of their families, homes, and communities. The Red Cross Home Nursing Course,\* which has been popular since 1914, is now one of the most used services of the organization.

In order that this service to the public may fulfill expectations and be applicable to community needs, the local Red Cross home nursing committee has become a vital cog in the wheels of a rapidly expanding program. The destiny of the program rests entirely upon the ability of the committee to undertake specific duties pertaining to administration; to recruit instructors, and see that they are adequately prepared for service in a new field; to stimulate the organization of classes; to secure suitable classrooms and equipment for teaching; to serve as an advisory body to the nurse instructors; to assist the chapter board in properly evaluating the service in terms of benefit to the community, and the financial committee by preparing an estimate of financial needs for the home nursing program.

Because such duties necessitate skillful guidance, the choice of a lay chairman for a Red Cross home nursing committee should be given careful consideration. One should be selected who is acceptable to the general public and possesses qualities of leadership, an inter-

est in the nursing profession, an understanding of community needs and resources, and a knowledge of Red Cross activities—in short, a worker, a good citizen, and a real “Red Crosser.” This choice is finally made by chapter officials, but the nurse may be helpful in making known to the board the qualifications desired in a chairman and names of women who might undertake the work.

A careful selection of committee personnel should be made by the chairman with the advice of the director of home nursing, the full-time instructor or chapter nurse, and other well-informed individuals. If it is to be an active and harmonious group, members should represent groups who show an interest in the program. They should have special abilities which make them useful in committee work, and both the desire and time to perform their particular duties well. It is often found that though the process be slow, potential abilities in committee members may be developed by first assigning them easy tasks, then more difficult ones, so that they feel rewarded and challenged by their increasing responsibilities.

In order that the committee and the director may know thoroughly their specific responsibilities, it is suggested they study together the American Red Cross Pamphlet 759 (revised February 1942) entitled “Information for Chapter and Committee on Red Cross Home Nursing.” Allocation of responsibilities to each member of the committee and clear definition of the extent of each one’s participation should then follow. The committee will thus from the first have well-thought-out plans for organization

\*For discussion of this Course from the point of view of the instructor, see “To Help You Teach Home Nursing” by Anna C. Gring, *PUBLIC HEALTH NURSING*, June 1942, page 315.

and function which will greatly facilitate their work. Good committee people are often frightened away by vaguely defined duties.

This organization procedure has worked satisfactorily in the Scranton Chapter in Pennsylvania, where the committee was reorganized about 15 months ago and a new committee chairman appointed by the Executive Committee. The road was not always easy but with the staunch support of committee and board, steady progress has been shown in all endeavors. In the first four months of 1942, as many classes were completed as in the whole of 1941. Twenty-nine qualified instructors have supplemented the original corps of eight instructors who taught before the reorganization took place.

#### COMMITTEE MEMBERS TAKE COURSE

As a prerequisite to membership and for their personal education, the entire committee completed the Red Cross Standard Home Nursing Course. Although one instructor to a class is the general rule, several qualified instructors taught the committee class so that they might sense the importance of personality, educational background, experience, and manner of presentation, in selecting nurses for teaching.

Nurse instructors were recruited through alumnae associations, the Office of Civilian Defense, the local Red Cross nursing service committee, local public health organizations, and hospitals. Individual nurses known to committee members or volunteering through the chapter office were also considered. Practically all were personally interviewed by the chairman. A preparatory course for nurse instructors was prepared and given by the chapter home nursing director with the assistance of the committee.

An equipment chairman was appointed to purchase and inventory supplies, and four sets of equipment were

secured by solicitation, gifts, and chapter assistance. Many articles were made by the committee members, and by local groups such as legion auxiliaries, clubs, and former students. Two permanent classrooms were provided by the Y.W.C.A. and a local utility company, and equipped with teaching aids and equipment as nearly as possible like that found in the average home. After the program started, a more comprehensive budget was prepared to buy additional equipment and to enlarge the chapter library, as well as to carry on adequately the present program.

As the program took form, one committee member took charge of publicity and prepared newspaper articles and pictures for release. Several radio broadcasts were made and one motion picture of a class under instruction was made for the annual meeting of a civic club. Short talks before organized groups made the county even more home-nursing-conscious. Each committee member who is to give talks is provided with an up-to-date outline containing the essential points to be presented, and with a list of open class dates. At the conclusion of the talk, while the enthusiasm is high, the speaker tries to complete plans for the organization of a class.

As chapter representatives, committee members visit all classes to introduce any new instructors and to manifest friendly chapter interest.

Soon the need for a tie-up with other professional groups became evident and a home nursing advisory committee—composed of the educational director of the visiting nurse association, a director of nurses and member of the Red Cross nursing service committee, and a professor of education—has agreed to conduct monthly home nursing conferences for instructors, with special speakers and demonstrations. This, we hope, will stimulate further study; bring current literature, techniques, and methods to

the group; and assist them with problems of teaching. The committee will also assist the home nursing director to revise the preparatory course and make it more applicable to the new instructors, for many of whom this is a new experience. The conferences and preparatory work will be held in the new chapter house in a classroom ideally equipped for the purpose.

Recently, the home nursing office was staffed with volunteers—each of whom has her regular day of service—who do all the time-consuming clerical work related to class organization. Each volunteer has completed the staff assistance course. A monitor is appointed by the staff assistance chairman, who schedules the volunteers' days of work and is taught the routine so that she can direct the others. A book of office procedures

has been compiled by the monitor and the director for the use of volunteers.

With our country at war, nurses are more in demand than ever. We are a group specially prepared to serve in an emergency. But more than that it is our obligation to preserve and strengthen the health of the nation so that it can meet *any* emergency, not just that thrust upon us by war. Willing hands can lighten our load, if we direct them in the tasks they are prepared to do. American women are known the world over for their many abilities. Why not let them perform the non-nursing activities of the home nursing program? Patience, careful planning, teamplay, and a submerging of self will make these programs a success, and prove that our profession with the help of American women can meet the needs of the day.

### School Child in Wartime

*(Continued from page 476)*

a. Has your school plans to reduce the number of school accidents, such as a monthly meeting of an accident committee to determine responsibility for each accident that has occurred—whether it resulted in injuries or not?

b. Has your school an educational program for pupils and parents, aimed to reduce home accidents?

c. Is first aid taught to older boys and girls?

d. Is the school active in the recruitment of adult students for first aid and home nursing classes, and does it assist in securing and preparing teachers for such classes?

e. Have you definite plans to help parents improve their health supervision of their children so that they will notice early deviations from health and know what to do about them?

f. Have you definite plans for teachers to report families with adverse health conditions, such as irregular hours of work, employment of mothers, or poor housing, so that you may give such families increased assistance in overcoming the effects of such conditions?

6. Are all possible motivations used and assistance given for securing early treatment of physical and emotional handicaps?

a. Are pupils interviewed by school physicians and interested teachers as well as by the nurse when treatment has not been secured?

b. Are contacts made with parents when interviews with pupils and notes to parents fail to secure treatment?

c. Are pupils who are to represent the school in athletics, music, drama, and other activities required to secure correction for remediable defects insofar as it is possible? Is this also a requirement for graduation?

d. Does the school co-operate with welfare officials and with nonofficial agencies in the use of existing treatment facilities and in interpreting the need for additional facilities?

7. Have you brought yourself up to date on the plans of your community for defense and for participation in the war effort, so that you are able to interpret these plans to the families of your pupils?

8. Have you reviewed your techniques in school nursing, general public health nursing, and basic nursing so you could use them with confidence in an emergency or teach them to inactive nurses?

MARIE SWANSON

*Supervisor of School Nursing  
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# Health in Trailer Camps

By ANN H. WANKO, R.N.

**I**N 1940 most of the residents of a certain midwestern county had visions of wonderful vacations in exciting places when they heard the words "trailer" and "trailer camp." They knew they might feel a little cramped, and not too fond of the people living on both sides of them; but they would have a good time, forget their problems for the present, enjoy good health. And when it was all over in two weeks they would go home, relax, and stretch out in a full-sized house to recuperate.

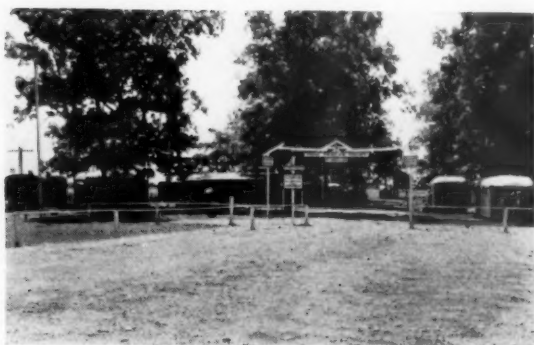
Since the rise of wartime industry the picture has changed. People are not on vacations, have not left the family home while they got "away from it all." Instead of crowded living for a short time, life in a trailer is now on a long term basis.

This story centers around a more or less rural county in the Middle West where there is a little more than the average amount of industrial activity. Private industry has been transformed into war industry and these private plants are working on a twenty-hour shift, bringing in a horde of new people to the community, just as is the government ordnance plant newly built in the county. People have migrated here from many states and the county population has jumped from 60,000 to 80,000 in a short span of time. Despite the fact that the area on the whole has always had adequate housing it could not begin to take care of the huge increase. Thus trailer camps and other makeshift dwellings shot up like mushrooms. All this brought many new problems to the county and state, including serious health problems with which we of the health department were most vitally

concerned. Lay committees so far have not seen the opportunity to help. There are two reasons for this—rationing of tires and the resentment of the old population toward their new neighbors who have come in uninvited to upset the serene pattern of living. At the present time there are 27 trailer camps ranging from the very bad to the almost ideal. The average number of trailers in each camp has been 50. The largest number in any camp has been 150. There have been as many as 542 trailers in the area and the average has been 338. Along with these, we have 115 small cabins in the trailer camps. All are privately owned. We have no Farm Security Administration trailer camps.

Our overworked sanitary engineer, who serves three other counties as well as ours, has been busy trying to enforce state rules and regulations. These cover grounds upon which the camps are located, and include provisions in regard to: drainage, safe water supply, sewerage, garbage and trash disposal, waste water, swimming pools and bathing beaches (where they exist), food sold on the grounds, public eating places on the grounds, health of employees, the trailers themselves, and competent camp supervision. Water-flushed toilets are required when their installation can be made at reasonable cost, and they must be connected with a public sewer system. If their cost is prohibitive, sanitary privies must be supplied. Waste water must not be allowed to collect on the grounds or contaminate the drinking water. Illness among employees and trailer occupants must be routinely reported by camp operators. Licenses for operating camps are required and may be





Panoramic view of an ideal trailer camp with good health facilities

Insanitary camp with makeshift facilities, a health hazard to all



revoked for failure to comply with regulations. Failure to obtain a license brings a fine and jail sentence.

#### A GOOD TRAILER CAMP

Our best trailer camp located one mile from the defense plant has 75 trailers—some owned by the camp and some by the trailer dwellers. There is a restriction of four persons to a trailer, with no more than two children to a trailer. This camp averages 20 children at all times. Available facilities surpass the state regulations and are as follows: 10 inside flush toilets, 9 showers with more than adequate hot running water at all times, laundry rooms with electric washers. Garbage and trash are hauled away from the camp and burned. Each trailer has running water for drinking purposes and a sewer system connection for sink drains. Water tests show the water supply to be one of the best in the state. No dogs are allowed. All streets are named and lighted, and trailers numbered. There is a parking lot for cars.

Trees are plentiful and recreation and playgrounds have been provided. Grounds are policed between midnight and morning. There are telephone service and a good doctor available at all times from a nearby town.

Persons owning their trailers pay \$2.50 a week for ground space plus light charges. Camp-owned trailers rent for \$10 a week plus lights.

The residents here are quiet, healthy, and happy and have taken an interest in the area around their trailers, planting grass and flowers. One man remarked that when he went to town he was always glad to get back because the camp was so clean and restful and quiet.

The other side of this picture shows us a camp with insanitary privies, a well with a pump, water test questionable, garbage burned on the grounds. There is a large hole dug in one corner of the lot for cans and other trash. Children play in the space between the trailers. There are no restrictions on the number of persons to a trailer.

Between these two extremes we have many variations, one of which I found rather interesting: Three discarded street cars have been rejuvenated and put into use. Each houses one family. Rent is \$3.50 weekly with light bill shared by all three families. The residents enjoy this small, clean camp set out in a large, clean field away from the highway. This however is not regarded by the health department as a trailer camp and does not have sanitary supervision.

In some instances we find grocery stores in these camps, and in others grocery service is brought to the camp by means of trucks from which the people buy directly. Here again standards of sanitation and cleanliness vary widely. While in a grocery store one day I saw a meat order being brought in by a trucker. Somehow during the process the meat fell to the floor and without hesitation the man picked it up and placed it in the display box as though this were an everyday occurrence.

This influx of people from many and varied places has increased our problems of communicable disease (including tuberculosis and venereal disease), maternal and child health, mental hygiene, school health, and many others.

#### PROMOTING HEALTH

In an effort to cope with these problems, the first move was to establish a district office of the State Board of Health with a medical director, a supervisory nurse, and two sanitary engineers. Besides this staff there were two public health nurses in the county and a third supplied by the U. S. Public Health Service at the request of the State Board of Health.

The engineers went to work inspecting and licensing the camps and enforcing the sanitary regulations. Monthly calls were then begun for water sampling and general inspection.

The three county nurses with the direction and help of the health officer and supervisory nurse conducted a countywide smallpox vaccination and diphtheria immunization program in an effort to establish protection against those two diseases. Surveys of the camps are being made by the nurses to find out the needs and problems of the trailer residents. When they are completed and the results tabulated, the nurses plan to be in the camps at scheduled hours to receive callers seeking help and advice. It is expected that a goodly number of women needing maternity care will be found; many preschool children not vaccinated or immunized against diphtheria; and most families without knowledge of a doctor to consult. Also, home visits will be made to teach better hygiene to the entire family living under very trying conditions.

Contact was set up with those in charge of the medical service at the ordnance plant, and tuberculosis and venereal disease patients are now referred to the health department.

Last winter during the height of the communicable disease season one of the nurses made arrangements with the operators of one of the camps for the use of an unused trailer. In this she inspected all the new school children in the camp each morning before they went to school. This was done for a period of six weeks and contributed appreciably to the low incidence of various diseases in the community.

Just recently a federal housing project was completed in the county and another is under construction. Under these roofs 14,000 people will find adequate and healthful living conditions and our trailer camp problems will no doubt decrease. We are planning to carry our program into the housing projects and to do a more extensive piece of health education work by means of films, talks, home nursing classes, and literature.

# Adjustments in a State Nursing Program

By HELENE BUKER, R.N.

**A**DJUSTMENTS in public health nursing made by the Michigan (State) Department of Health to meet the present emergency include a careful analysis of our program, new activities of the Bureau staff to meet new demands, and various changes in relation to local nursing programs. The Bureau of Public Health Nursing since 1938 has been one of the 12 bureaus of the Michigan Department of Health.

Present professional personnel of the Bureau are the director, assistant director, and eight consultants. No nurses on a staff-nurse level are employed directly by the Bureau, but state and federal funds are allocated to local health departments for employment of field nurses. The local departments almost always call upon the Bureau for referral of qualified applicants. Of 83 counties in Michigan, 66 are now served by full-time county or district health departments.

In the early days of the defense program, the major defense activities of the Bureau staff, especially the director, were those connected with various committees such as the State Nursing Council on Defense, the State Committee on Red Cross Nursing Service, an S.O.P.H.N. committee on lay participation, and subcommittees of the State Nutrition Defense Committee.

In more recent months, varying degrees of adjustment of our services have been required to cope with changing situations. We have had to do much analyzing and rethinking of our program, and to take on new and unexpected activities, a few of which I will describe.

## *1. Preparation of Red Cross home nursing instructors*

As the Red Cross program for teaching home nursing was speeded up, with authorization of many new instructors, the Committee on Red Cross Nursing Service and the Bureau of Public Health Nursing became concerned over the inadequate preparation of potential teachers, which included currently inactive nurses. But the task of training teachers was too great for the Red Cross alone. In January the W. K. Kellogg Foundation offered its resources for defense activities. The need for preparation of nurses for group teaching appealed to Foundation representatives as a worth-while project. They offered the use of one of their camps and other aid in the development of workshops for nurses. Co-operation of state nursing groups was secured. The assistant director of the Bureau managed recruitment and assignment of nurses for the camp. For several weeks most of her time was occupied with the project. Consultants of the Bureau took turns acting as "resource people" at the camp. Approximately 200 Michigan nurses attended the one-week workshops during the first five weeks, after which the camp was made available to nurses of other states.

## *2. Emergency medical services*

In February, the Governor appointed a member of the Michigan Department of Health as chief of emergency medical services, Michigan Citizens Defense Corps, and the Department was asked to assume responsibility for the statewide organization of emergency medical services. The assistant director of the Bu-

reau of Public Health Nursing was appointed nursing deputy to the chief of emergency medical services. She and the executive secretary of the Michigan Nursing Council for War Service (formerly the State Nursing Council on Defense), who is employed by the Michigan State Nurses Association, work closely together. They have prepared a nursing supplement to the Administrative Manual for Emergency Medical Services Division of the Michigan Citizens Defense Corps. The assistant director of the Bureau is devoting much of her time to organization of nurses in local areas. The executive secretary of the Council works on recruitment of student nurses and other phases of the program.

### 3. *State consultants' program*

Six of our eight consultants have been assigned to regional areas for generalized advisory service; five of them also carried the responsibility for one of the specialties—maternal and child health, school health, tuberculosis, venereal disease, and industrial nursing. The demands of industry have become so great recently that the industrial nursing consultant has been released from generalized service so that she may devote all her time to industrial nursing.

To conserve tires and gasoline, the consultant nurses have decided to make longer and less frequent visits to local health agencies and to return to headquarters less often.

Additional demands upon Bureau staff time for wartime services have meant that some activities previously planned have had to be postponed or abandoned.

In addition to Bureau staff adjustments, changes have also been made in relation to local nursing programs.

#### CHANGES IN LOCAL PROGRAMS

##### 1. *Educational program*

Now when the need for nurses is so

great, it does not seem wise to have nurses leave the field for further training. For this reason it is planned to use the few available Social Security Act subsidies to prepare new nurses for public health nursing positions. Stipends will be given for one semester only, and unless a nurse has already had the equivalent of a semester she will be asked to take one additional semester at her own expense. Many have already indicated their willingness to do this.

##### 2. *Field experience*

This past year a sum of money was budgeted to pay salary and travel of nurses needing supplementary field experience to prepare them for public health nursing positions. Several have so far received one to eight months' experience in a rural training center, and two are now gaining field experience in a visiting nurse association. We are considering some rural field experience as a refresher course for several nurses who wish to return to work after having been inactive in public health nursing for several years.

##### 3. *In-service education*

In-service education programs for the coming year are being developed mostly within each local county or district health department area to save the time and travel involved in regional and statewide conferences.

##### 4. *Qualifications of nurses*

The Michigan Bureau of Public Health Nursing does not at this time favor lowering qualifications of nurses. Exceptions may—as always—have to be made in some cases. As yet our shortage of public health nurses is not acute. On January 1, 1942, we had in the state only two less nurses than on January 1, 1941, exclusive of industrial nurses whose numbers have increased considerably.

### 5. *Lay committees and volunteers*

To find out more about lay committees in official agencies and the types of services rendered by them, a questionnaire was sent to county, district, and city health departments. Some interesting facts were received from 20 counties having lay committees, of which I will mention a few.

Nearly 1100 women and 75 men are serving on the 20 committees. Meetings are held monthly in half the counties—less often in others—and the programs are usually educational. In many of the counties there are township or district work committees organized for the purpose of planning for health needs of the individual local communities, and assisting in various kinds of service projects. A goodly number of volunteer services were listed, but only one county had any special plan for introduction of volunteers. Many counties were receiving volunteer service from other organized community groups. Despite some encouraging reports we realize that the reservoir of volunteer assistance has hardly been tapped, and that this source of help can be of inestimable value in the difficult times ahead.

In order to stimulate the use of volunteers by local health departments, mimeographed material was prepared by members of the Bureau of Public Health Nursing, entitled "Suggestions for Training Volunteer Workers in Local Health Services." It includes information on the selection and varied uses of volunteers and suggested procedures for their introduction and orientation.

### 6. *Defense areas*

Michigan has many defense areas—a few military, the majority industrial. Their problems are being met in various ways. Stimulated in part at least by defense needs, three counties have organized health departments during the past year, and several others are

considering this move. In the meantime, two or three counties are giving the Michigan Department of Health much concern because of the serious problems they present. For several years it has been a policy of the Department to give all assistance possible to well-organized county health services but not to place workers in unorganized counties. Now the advisability of changing this policy, in one county in particular, is being considered.

Four nurses supplied by the U. S. Public Health Service are giving excellent service in defense areas, and federal funds for venereal disease control are making it possible to employ extra nurses in other strategic localities. The Bureau of Public Health Nursing is advising that nurses employed from special venereal disease funds carry on a generalized service and that all other staff public health nurses participate in the venereal disease program.

The state maternal and child health nursing consultant is planning to survey some of the defense areas to determine how well the needs of mothers and children are being met.

### 7. *Program planning in local areas*

In helping local health departments plan their services, some things are being stressed which we hope will be of lasting benefit. Among these are:

Analyzing services to determine where efforts will be most effective.

Co-operative planning with other agencies administering public health nursing in the community.

More careful planning of visits to save time and travel.

More bedside nursing care of the sick, at least for teaching purposes.

More intelligent use of nursing service in communicable disease programs.

Organization of child health conferences in areas where this seems feasible, and introduction of maternity classes and other group education.



Use of volunteers in every way possible.

Participation in local civilian defense activities. A list of services in which health department personnel might make a special contribution has been sent out by the Michigan Department of Health.

The morale of nurses, as well as that of the families they serve, frequently needs to be bolstered up at this time. Public health nurses feel the pull of military service and are sometimes afraid they will be considered slackers if they stay to serve the civilian population. For this reason especially, they are glad to participate in special defense activities.

All nurses are encouraged to take courses in first aid, and to teach first-aid and home nursing classes if needed.

#### 8. *Recruitment of public health nurses*

Recruitment of nurses for service in local health departments is at present one of the time-consuming functions of

the Bureau staff, and we anticipate that nurses will become increasingly difficult to find. A few married nurses who have not been actively engaged in nursing are indicating a willingness to return to the field. It is planned to locate more of this group through the national survey of nurses, and by publicity. Plans for refresher courses or field experience for some of them will have to be made.

To date we have not had to make very drastic changes in the Bureau of Public Health Nursing program, but we are attempting to keep it flexible and to be ready to meet whatever demands the future brings. The functions of the Bureau remain the same, but they have had to be re-interpreted and stretched to fit the expanded pattern of needs for service.

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Presented before the N.O.P.H.N. Round Table on Administrative Plans for the Emergency, Biennial Convention, Chicago, Illinois, May 21, 1942.

### CLARIBEL A. WHEELER RETIRES

RETIREMENT from work well done and an enviable ten-year record of important tasks completed should be an occasion for rejoicing; yet public health nurses will hear with regret of Claribel A. Wheeler's resignation as executive secretary of the National League of Nursing Education. Miss Wheeler has given nursing education in all its aspects skillful, effective, and far-sighted guidance. Most noteworthy among the accomplishments of the League under her leadership have been the completion of *A Curriculum Guide for Schools of Nursing* and many other important studies and publications, made possible through her able guidance and direction of committees; and the initiation of

an accreditation program for nursing schools.

The League, working on a small budget with a small staff, has kept faith with the highest ideals of nursing education. Much of the credit is due Miss Wheeler, who has fought tirelessly to solve practical difficulties without a compromise of standards. Public health nurses are especially appreciative of the extended opportunities for advanced nursing courses which Miss Wheeler's interest has promoted. Our best wishes go with her as she seeks a much-needed respite from her national responsibilities.

DOROTHY DEMING, R.N.  
New York, N.Y.

# How One Agency Meets New Situations

By DOROTHY J. CARTER, R.N.

**W**HEN PLANNING administrative adjustments for a public health nursing agency these days one feels rather like the White Queen in "Alice" who, you remember, always blithely started off the day by "doing six impossible things every morning before breakfast." That is almost what is demanded of us at the present time—there is more to be done, less time to do it in, and less personnel to do it with.

The adjustments we have undertaken in the Community Health Association, which is the visiting nurse association for Boston, fall roughly under the following headings: adjusting program, reducing expenses, increasing income, replacing personnel, meeting new needs.

Under program adjustments we have been studying how we could eliminate any unnecessary service or visits with a view to saving nurses and nursing time. Were there services in which we could expect the family to take more responsibility than they had in the past? Were there ways we could test our teaching to see if our families really have benefited?

We selected our normal prenatal cases to begin with. We are the only public health nursing agency in the city that gives prenatal nursing care. We usually make, therefore, over 30,000 visits a year to these patients—a considerable number, averaging between four and five visits per case. We believed we could reduce our home visits to normal cases who are under good clinic supervision and put more emphasis on group teaching in our mothers' clubs—a big saving. This we have now decided to do. The recent changes in policy made by the Metropolitan Life Insurance Company in

regard to visits to maternity cases were also a factor in this decision.

Thus at the present time our policy for visiting prenatal patients is as follows:

1. For normal cases under adequate medical supervision, either private physician or clinic—

Emphasis to be placed on attendance at mothers' club for prenatal instruction and guidance.

One or two home visits only for evaluating the home situation and for individual conference and instruction.

2. For abnormal cases (with "abnormal" interpreted rather broadly)—

As many visits as necessary.

In analyzing the needs of each prenatal patient we use the following as criteria:

1. What are patient's educational background, capacity to learn, and willingness to accept teaching?

2. Has she been registered with us for prenatal service in previous pregnancies? Did she attend mothers' club?

3. Has she ever had assistance from the nutrition service—budget, meal planning, marketing, diet therapy? How much of this teaching did she absorb?

4. Is she a primipara or multipara?

5. What are her plans for confinement—home or hospital? If home delivery, has she had a home delivery before?

6. How soon did patient report for medical supervision in previous pregnancies?

7. Is she being seen at clinic or by private physician regularly? Has she a history of abnormal pregnancies? Is the present pregnancy complicated by cardiac condition, tuberculosis, or other serious conditions?

8. What assistance does the patient want during this pregnancy?

9. What do we see as her needs?

Since our home deliveries have decreased in the last few years, we have closed one of our four delivery centers.

We still believe it is essential, however, to continue this service, since eventually there may be an increase in home deliveries because of the uncertainty of the hospital situation.

For a number of years we have made a special effort to keep our load of long-time or chronic patients at a minimum. To help our staff with this ever-present problem we have a special committee made up of three supervisors and two of our board members which meets every few weeks to consider those cases presenting a special problem in regard to length of service, fee adjustment, or other difficulty. Any case with which the nurse or supervisor would like help may be presented, and the committee makes the decision as to the disposition of the problem.

We are co-operating with our large maternity hospital here by having our nurse assist in two of the weekly prenatal clinics held in the health centers. Because of the shortage of doctors and nurses the hospital has had to close some of its district clinics, but with the co-operation of our Association they are able to continue these two which otherwise might have had to be closed. Since all prenatal patients are referred to us anyway for nursing supervision, it helps very much to co-ordinate the service by having our nurse right in the clinic.

Most of the adjustments just described were made primarily to reduce service and thus save nursing time, personnel, and also expense. On the other side of the ledger, in December 1941, we raised our fee for a nursing visit from \$1 to \$1.25 and our delivery fee from \$6.25 to \$10, thus actually covering the cost of the service for the first time in a number of years. With the increase in employment and higher wages generally we thought that those who could pay at all could pay the higher rates. So far this year we are \$1500 ahead of last year at this same time in fees from patients, despite a reduction in cases and visits.

#### REPLACING PERSONNEL

We have lost 27 nurses since January 1, 12 of whom have gone into army service. While we have not as yet had too much difficulty in getting replacements we realize the problem will increase as time goes on. We have made contact with as many as possible of our former staff members living in the vicinity to see how many would be available for full-time, part-time, or substitute work if necessary.

During the past year we have been trying to develop a better-organized volunteer program than we have ever had in the past, under the leadership of a small committee made up of board and committee members, with one of our district supervisors as leader for the professional group. Due to their efforts we have had a small but faithful group of volunteers assisting with clerical duties and in our mothers' clubs and low-cost food classes.

This past winter we have conducted two experiments with auxiliary workers, one with attendant nurses and one with Red Cross Volunteer Nurse's Aides. Since we are fortunate in Boston in having one or two good courses for training attendant nurses, we took two on our staff last year to help us with chronic patients during the winter months. One is still with us and her work is very satisfactory. Two groups of nurse's aides have come to us for a short introduction to public health nursing following their Red Cross Volunteer Nurse's Aide Course and their first period of hospital service. They spent half days for a two-weeks' period with the nurse on her rounds and assisted with care in the home. As a result of this experiment we believe there is a definite place for the aides in our program and we hope that some plan may be worked out with the Red Cross for using them in an emergency period.

Needless to say we attempt to do

more teaching than ever before in every home visit, with a view to making our families as responsible as possible. Some of our nurses have been teaching Red Cross home nursing classes on their own time, and now we are allowing a limited number to teach classes in their own districts on organization time. We are also incorporating some teaching of simple home nursing procedures in our regular mothers' clubs.

Our staff is on call for the mobile first aid units in the civilian defense setup. While inactive nurses have volunteered for first aid units, not enough were available to fill the quota, so the local health agencies have found it necessary to supplement the units with their own staffs.

#### FUTURE NEEDS AND PLANS

In the event of an epidemic the nursing staff of the Boston Health Department and our staff are planning to work together, pooling the two groups as far as possible. A beginning has been made by giving demonstrations of bedside technique to the health department staff.

The typhoid inoculation records of our staff have been rechecked and every nurse not immunized within the last two years has been inoculated.

We have been considering the possibility of using senior staff nurses as assistant supervisors in some of our

larger districts where we have assistants regularly assigned. If we do this, we would plan to assign some of the duties usually carried by the assistant supervisor to various members of the staff group and give each senior staff nurse the opportunity to act as assistant for a few months at a time. Whether this would be a saving we are not sure, but it might save something in the salary budget for assistants. In addition it would give increased opportunity to try out promising staff nurses as assistant supervisors.

We believe it very important to carry on our usual student program in affiliation with the program of study in public health nursing at Simmons College.

In conclusion, we believe it important to do two things which may seem in a sense paradoxical: First, we must keep the staff constantly stimulated and on the alert to make any adjustments in procedures or program that will conserve time and expense; at the same time, we must continue to instill in them as much of a feeling of security and stability as possible, so that they may in turn transmit this to the families they serve. This last is one of our biggest contributions.

Presented before the N.O.P.H.N. Round Table on Administrative Plans for the Emergency, Biennial Convention, Chicago, Illinois, May 21, 1942.

#### FUNDS FOR PREPARING MORE NURSES

**A**N APPROPRIATION of \$3,500,000 has been made by Congress for preparing an increased number of nurses to meet war needs during the year beginning July 1, 1942. These funds are available for basic nursing programs, refresher courses, and advanced curricula to prepare for positions in schools of nursing, hospitals, public health, anesthesia, and midwifery. Funds are allotted by the U. S. Public Health Service directly to eligible schools of nursing which can increase their admissions over the school year 1940-1941. They can also be allocated—even to schools which cannot increase their admissions—for scholarship tuitions for qualified students who could not afford to pay their own tuition.

# Wartime Shifts for Public Health Nurses

By RUTH A. HEINTZELMAN, R.N.

**I**NFORMATION regarding supply and distribution of public health nursing personnel was requested from 15 state health departments in preparation for a round-table discussion at the recent Biennial Nursing Convention in Chicago. Directors of public health nursing in 15 Midwestern and East Central state health departments were sent questionnaires. Replies were received from all of the states. The data described conditions as they existed on May 1, 1942. The six questions, requiring only brief answers, were as follows:

1. How many vacancies in public health nursing positions existed on the state and local health department staffs on May 1, 1942?
2. What plans are being made to fill the vacancies?
3. What changes are contemplated in community organization for public health nursing services to meet the need created by a limited supply of nurses?
4. Has it been possible to uphold the requirements for appointment that prevailed in your agency on January 1, 1942?
5. What volunteer services are utilized by the public health nurses in your agency?
6. Is the need greater for staff nurses or supervisors?

## VACANCIES

The replies indicated that a total of 17 vacancies existed in state and local health department supervisory positions; and 139 in staff positions in local health departments. Six states reported no vacancies in supervisory positions, either state or local; no state had more than 3. One state reported 29 vacancies in local staff nurse positions; one state, none. The average number of staff nursing vacancies was 9 plus; the average number of state and local supervisory positions, 1 plus.

## WHAT NURSES ARE NEEDED?

Question six in regard to relative needs for staff nurses and supervisors brought a variety of replies. Nine states reported a greater need for staff nurses; 2, a greater need for supervisors. The other states said either that the needs for both were equally great, or that while possibly staff nurses were more needed, supervisors were also essential.

## PLANS FOR FILLING VACANCIES

The states are exploring many possibilities for filling vacancies and are making plans to this end. Seven states look to stipend students returning from university study. Three are recruiting for the official health services, nurses completing public health nursing courses this summer. One thinks increased salaries will help. Five states report recruiting of inactive public health nurses; 2 have refresher courses to prepare these nurses for service. One state has let down the barriers against married nurses. Other states are variously utilizing professional placement services to fill vacancies, canvassing other agencies, and recruiting recent graduates from schools of nursing and graduate, registered nurses. There is mention of special public health nursing training for graduate nurses who need it.

## COMMUNITY ADJUSTMENTS

Question three has to do with community changes to meet the need created by the limited supply of public health nurses. Seven states reported "no changes." Two states will combine small counties where the population is sparse and spread the services of the public health nurse. A number of states



see possibilities of generalizing nursing services and combining official and non-official services.

#### MAINTAINING REQUIREMENTS

In question four, problems relative to maintaining requirements for appointment are considered. The directors of 11 states have been able to uphold the requirements which prevailed in January 1941. Only one state reported that requirements had been lowered. The remainder stated there had been few if any exceptions to the usual requirements.

#### VOLUNTEER HELPERS

All 15 state directors said that volunteers are used by public health nurses functioning in health department programs. Active aid has been given by groups and individuals such as nursing or public health councils and committees, parent-teacher associations, junior leagues, American Legion auxiliaries, tuberculosis committees, Volunteer Nurse's Aides, farm bureau members, and married and inactive nurses. Volunteers have taken part in such activities as assisting in well child, maternity, and immunization clinics and conferences, making supplies, making limited home visits, transporting patients, teaching home nursing and other types of study groups, organizing loan closets, raising funds, furnishing public health books to the local library, and giving clerical help. In one state which recently collected information on volunteer services, it appeared that while health departments are using volunteers, their service could be utilized to a much greater extent. This same state makes available to local

health services suggestions for training volunteers.

In attempting any analysis of distribution of public health nursing service during the war emergency, it is well to remember that public health nursing personnel has not been adequate in normal times to meet the needs of the many services which are part of the expanding programs of public health. This analysis, therefore, does not present the entire picture. There are many counties in this country without public health nursing service, and areas without adequate nursing supervision. Both these conditions existed before the war emergency. With the increased demands of the war effort upon the nurse power of the country, we should ever consider how to utilize to the best advantage the available public health nursing personnel.

The need for a more effective distribution of personnel is recognized. The problem is to find ways and means to bring it about. In spite of all that we say about integration of service, many cities and counties still have public health nursing administered by a variety of agencies, with programs that overlap in areas and in services. This is the time to eliminate all such expensive and unnecessary duplication. State nursing councils for war service may provide the machinery through which professional nursing groups can stimulate better coordination of existing public health nursing services in local communities.

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Presented before the Round Table on Adjustments in Supply and Distribution of Public Health Nursing Personnel, Biennial Convention, Chicago, Illinois, May 19, 1942.

**Industrial nursing will be given special emphasis in the October issue.**

# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

## CHANGES IN N.O.P.H.N. STAFF

IT is with very real regret for the N.O.P.H.N., but hearty congratulations to Worcester, Massachusetts, that we announce the resignation of Ella L. Pensinger, who on October 1 will become the educational director of the Worcester Society for District Nursing.

Miss Pensinger came to the N.O.P.H.N. staff as assistant director in May 1939, and has carried a variety of important responsibilities here. She is secretary of the Eligibility Committee and in this capacity carries on much of the correspondence with agency members of the Organization. She is also secretary of the Joint Committee on Community Nursing Service.

Miss Pensinger is well known in many parts of the country because of the studies of public health nursing which she has made in a number of communities. And many individual nurses will remember her for her thoughtful vocational guidance. A large number of people, and particularly her staff associates, will miss Miss Pensinger at N.O.P.H.N. headquarters, but we believe she is ideally fitted for her new position and wish her much happiness in this new undertaking.

WE TAKE pleasure in announcing that Ruth Fisher, for ten years director of the Visiting Nurse Association of Plainfield and North Plainfield, New Jersey, will come to the N.O.P.H.N. staff as assistant director on September 1. She will take over many of the duties now carried by Ella L. Pensinger including that of secretary of the Council of Branches.

Miss Fisher is a graduate of the Army



Ruth Fisher

School of Nursing and took her post-graduate work in public health nursing at Teachers College, Columbia University, where she also received her B.S. degree. Besides her work in Plainfield, Miss Fisher has held positions with the Maternity Center Association in New York City and with the Dutchess County Health Association, Poughkeepsie, New York.

Her experience in Plainfield has included all types of public health nursing, since the V.N.A., through a combination with the health department, gives all public health nursing service in the community.

The N.O.P.H.N. considers itself most fortunate in this critical period to secure as a staff member a nurse whose reputa-

tion for good judgment and common sense is well known in public health nursing circles.

THE N.O.P.H.N. feels fortunate to secure the services of Mrs. Bethel J. McGrath of Minneapolis for carrying on a special project, started in 1941, of preparing a handbook on industrial nursing. Mrs. McGrath is lent to us by Powers Dry Goods Company, Inc., of which she has been industrial nurse since 1933. Her title is director of welfare. She is a graduate of Presbyterian Hospital School of Nursing in Chicago, has taken courses in public health nursing at the University of Minnesota, and is a certified public health nurse in the State of Minnesota. Before entering the field of nursing she took special work in social service and was on the staff of the social service department at the University of Michigan Hospital at Ann Arbor for a year. She has been chairman since 1939 of the Industrial Nursing Section of the Minnesota State Organization for Public Health Nursing and represents industrial nursing on the State Nursing Council for War Service, the board of directors of the Third District of the Minnesota Nurses Association, and *The American Journal of Nursing* Committee. In preparing the handbook, Mrs. McGrath will work with committees composed of industrial nurses in various parts of the country. She will spend part of the time at N.O.P.H.N. headquarters in New York and part of the time in Minneapolis, so that she may serve as consultant to her firm while working on the handbook.

#### FIELD SERVICE

The month of August saw continuation of field work on two studies now being made by the N.O.P.H.N. Hortense Hilbert and Sybil Palmer Bellos visited three communities in the Midwest to study public health nursing resources

for care of the sick. Evelyn C. Nelson and Mary M. Macdonald observed a number of clinics on the East Coast in connection with the study of nursing services in clinics.

#### ORTHOPEDIC CONFERENCE

A GROUP conference on orthopedic nursing will be conducted by Jessie L. Stevenson, October 25 and 26—the two days preceding the convention of the American Public Health Association to be held in St. Louis, Mo. This conference is planned primarily for nurses actively engaged in crippled children's services. Registration is limited to 30 and will close October 1. Applications should be addressed to Jessie L. Stevenson, Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York, N. Y.

#### ORTHOPEDIC NURSING COURSES

THE urgent need for skilled nursing care of orthopedic patients has been greatly increased by present war conditions. The number of casualties who will survive this war and need rehabilitation will undoubtedly be greater than after any previous war. For this reason advanced courses in orthopedic nursing and physical therapy should be given careful consideration by all nurses. A list of approved schools for physical therapy technicians appeared in the June issue of *PUBLIC HEALTH NURSING* (page 328). Special programs of study in advanced orthopedic nursing are offered by the following universities:

1. Teachers College, Columbia University, New York, N. Y. For further information write to the Division of Nursing Education, Teachers College, Columbia University.
2. Western Reserve University, Cleveland, Ohio. For further information write to the dean, School of Nursing, Western Reserve University.
3. University of Minnesota, Minneapolis, Minn. For further information write to Department of Preventive Medicine and Public

Health, 121 Millard Hall, University of Minnesota, or the School of Nursing, Medical Sciences.

4. New York University, New York, N. Y. For further information write to Dr. George C. Deaver, School of Education, New York University, Washington Square.

### ORTHOPEDIC SCHOLARSHIPS

**A**PPPLICATIONS for the orthopedic scholarships made possible by a grant to the N.O.P.H.N. and the National League of Nursing Education from The National Foundation for Infantile Paralysis will be accepted until October 1, 1942. These scholarships are for the preparation of nurses for orthopedic teaching and supervising positions in public health agencies and hospitals. The grant is a renewal of one made by the Foundation last year, and shows its recognition of the great importance of skilled nursing care for patients with orthopedic disabilities. Adequate care of these patients becomes increasingly necessary in time of war, and the need for nurses with orthopedic preparation is a very pressing one.

Nurses and others who are interested in obtaining additional information about the scholarships should write to the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York, N.Y.

### HONOR ROLL

Over 1000 agencies can now point with pride to their Certificate of Honor which indicates that every staff member has joined the N.O.P.H.N.

Be sure to send us a card when your staff is 100 percent enrolled so that your agency may be included in the next list published. One-nurse agencies are equally eligible for this certificate when their nurse is a member.

#### ALABAMA

\*Franklin County Health Department, Russellville

#### CALIFORNIA

Metropolitan Life Insurance Nursing Service, Oakland

#### CONNECTICUT

Washington Visiting Nurse Association, Washington Depot

#### IDAHO

U. S. Indian Agency, Fort Hall Nursing Service, Fort Hall

#### ILLINOIS

\*Metropolitan Life Insurance Nursing Service, Oak Park

#### IOWA

Guthrie County Nursing Service, Guthrie Center  
\*Visiting Nurse Association, Sioux City

#### INDIANA

Madison County Chapter, American Red Cross, Anderson

#### NEW HAMPSHIRE

\*State Board of Health, Division of Public Health Nursing, Concord

#### NEW JERSEY

\*Long Branch Public Health Nursing Association, Inc., Long Branch

#### NEW YORK

Purchase Nursing Committee, Health Center, Purchase

#### NORTH CAROLINA

Asheville City Health Department, Asheville  
Hertford-Gates District Health Department, Winton

#### NORTH DAKOTA

\* Fargo Health Department, Fargo

#### OKLAHOMA

Osage Indian Clinic, Pawhuska

#### PENNSYLVANIA

\*Henry Phipps Institute, Philadelphia  
\*Negro Bureau of the Philadelphia Tuberculosis and Health Association, Philadelphia

#### TENNESSEE

\*Rutherford County Health Department, Murfreesboro

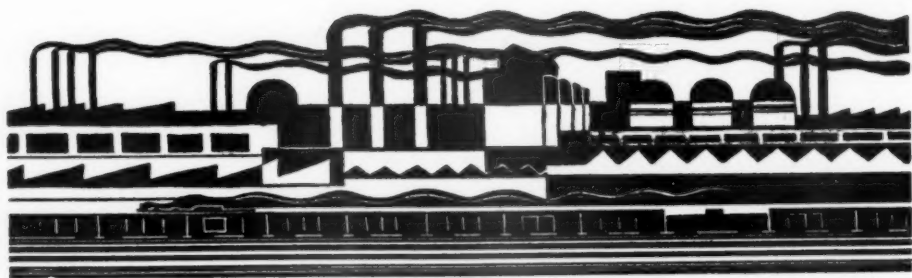
#### VERMONT

\*Metropolitan Life Insurance Nursing Service, Rutland

#### ALASKA

Fairbanks Department of Health, Fairbanks  
Petersburg Department of Health, Petersburg

\*Agencies which have been on the Honor Roll for five years or more.



## REHABILITATION

FOR SOME years, many of the large and small factories of Michigan have co-operated in tuberculosis work by x-raying new employees and reinstating ex-patients in lighter occupations. With the rehabilitation of these patients and retraining into higher skills, the interest of industrialists in this co-operative activity has been greatly intensified.

In Saginaw, a rehabilitation committee has been organized to find, investigate, and refer to the vocational rehabilitation department all physically handicapped people of that area. This committee is composed of various business men in the city, as well as representation from the county tuberculosis

association and the county medical staff. A similar committee is being set up in Muskegon.

Genesee County, ranking third in the state in population but with no sanatorium, has had a rehabilitation program in its county tuberculosis association for the last two years, for all ex-patients returning to that county. Here they have been able to reduce to a fraction the amount of money spent per month by the welfare agency on families of ex-patients, where the patients are employable.

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From "Common Denominators," by Helen Wilson, *Bulletin of the National Tuberculosis Association*, May 1942, page 70.

## NEW PROBLEMS IN INDUSTRIAL MEDICINE

RECOGNIZING that the change-over of industry to the manufacture of war materials has modified ordinary industrial hazards, introduced new occupational disease exposures, and necessitated variation in industrial medical procedures, the Division of Industrial Hygiene of the National Institute of Health is preparing a handbook on "Industrial Hygiene and Medical Service in the War Industries." This should have wide distribution among industrial and other physicians who are called upon to pro-

tect the health of workers in war industries, and will be of great interest and value to industrial nurses. The Committee on Industrial Medicine of the National Research Council recommended the preparation of the handbook in a resolution giving the following illustrations of new industrial medical problems:

1. There is increased usage of cutting oils, compounds, and chemicals, many of which are capable of causing the industrial dermatoses.
2. Grinding operations have multiplied and these entail exposures to aluminum oxide, silicon carbide, and other grinding materials.



While the dusts from grinding operations have not been regarded as harmful to health, disabilities occurring in workers so exposed are coming to be regarded as compensable.

3. Shot blast operations are being replaced by sand blasting, and new installations of this nature are consistently using sand.

4. In an effort to speed up pickling operations, there is a tendency to increase the concentrations of acids in the pickling tanks, with consequently more contamination of the air with fine droplets of the acids.

5. Solvents are being more widely used and certain of the newer ones are purported to be non-toxic. Inasmuch as most of them are in the chlorinated hydrocarbon group of chemicals, they can be assumed to be more or less toxic.

6. Paint spraying operations are being modified, requiring radical readjustments in ventilation procedures.

7. There is a tendency toward longer working hours and, consequently, longer hours of exposure to harmful materials and shorter periods of recuperation.

8. It is becoming more and more necessary to employ women, older men, and young men who are not eligible for military service, many of whom require selective placement, which is a function of the plant medical service.

9. It is necessary that the medical service in the war industries be integrated with the emergency medical service of civilian defense. Details necessary to this objective are not understood by the industrial physicians as yet.

## PREVENTION OF BOILS

**P**UBLIC HEALTH NURSES will be interested in a series of recommendations for the prevention of one type of boils made by experts of the U. S. Public Health Service.\* Incidentally, these grew out of an investigation by the Service of an epidemic of boils in a Colorado hard-rock tunnel building project. It was found that the skin lesions, chiefly on wrist and neck, were not caused by bacteria or chemicals in the floor water or rock dust in the tunnel, but by a combination of factors which brought about a lowering of skin resistance to pyogenic bacteria.

The authors state that the humid atmosphere, the perspiration, the warm tunnel water, friction from clothes and rubber coats infiltrated with rock dust, together with the unhygienic conditions of the tunnel, and the insanitary and dirty condition of the working clothes caused the outbreak. The prime requisite in the prevention of boils among tunnel workers is said to be personal cleanliness, obtained by having:

1. Adequate, usable bathing facilities, the showers having controllable hot and cold, uncontaminated water.

2. The workmen to be furnished a toilet

soap and clean towels each time they use the shower.

3. The foreman of the work gang should supervise and enforce adequate bathing after work.

4. Daily change to clean work clothes, with clean neck towels to be provided for the workmen. Each workman should have three changes of work clothes. (Clean clothes and towels may be had by contracting with a laundry for this service at approximately fifteen cents a day per man.)

5. Individual raincoats, rubber boots, safety hats, respirators, and neck towels.

6. Daily washing of the rubber clothing worn by the men.

7. Sanitary toilet facilities in the tunnel. If permanent ones are impractical, portable sanitary pails for toilet use are suggested.

8. The workers should be taught that if occasional boils appear in spite of these protective measures, they should seek early medical aid and not treat themselves.

9. The men should be advised not to use adhesive tape on the skin because its removal pulls out the hairs, the open hair follicles becoming new portals for infection.

10. A series of health talks should be instituted to give a background to the workmen for a practical and workable personal hygiene program.

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\*Gant, James Q., Owens, Robert J., and Schwartz, Louis. "An Epidemic of Boils in a Group of Tunnel Workers." *Public Health Reports*, April 24, 1942, page 616.



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EDITED BY EVELYN C. NELSON

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**SOLVING SCHOOL HEALTH PROBLEMS—  
THE ASTORIA DEMONSTRATION STUDY**

By Dorothy B. Nyswander, Ph.D. 377 pp. The  
Commonwealth Fund, New York, 1942. \$2.

This book presents the results of four years of experimentation in school health practices in the public schools of New York City. It incorporates the findings of a demonstration study of school health work in the Astoria Health District, one of the thirty districts into which New York City has been divided for administrative purposes by the Department of Health. Each procedure of the school health service staff was subjected to careful scrutiny and measurement where possible to ascertain its effectiveness in improving child health.

The study aimed not only at applying the results of previous research, but in addition, it endeavored to arrive at standards which would overcome much of the criticism now being leveled at school health work, through a careful appraisal of activities of the school personnel. In many instances time-worn practices had to be discarded and newer methods substituted. In other cases, the results obtained made it necessary that personnel immured in old practices be educated in new ways of work and thought.

One thing that must be borne in mind in a study of this character and setting is that the results, while significant and

timely in their appearance, may not always apply in other communities engaged in furthering the health of school children. School health personnel must of necessity adjust their activities to the size of the school population assigned them. Moreover, what may apply in one city where school health personnel are provided by the board of health may be of no value in a city where the board of education employs its own school health staff.

The findings discussed in this report are of such significance as to make them *must* assignments for school health personnel, wherever they may be. From a strictly administrative standpoint, they call for special attention because of their effect in shaping future policies and relationships between the board of education and the board of health. The report emphasizes that clear statements of policy are needed from both organizations to avoid duplication of effort and otherwise delineate functions. Cooperation of this sort must start at the top, and permeate downward into all divisions of each organization.

The reader is warned not to expect in this report answers to all problems of direct concern to the school health service. Instead, he should regard this as a progress report since the Study Staff has purposely exposed many problems for consideration which remain unsolved.

As a research project this report is very well organized. The author is to be commended for the clarity of her style of writing and the method used in presenting her data. Not only has she given a clear picture of conditions before and after the study, but more important, her efforts have been directed at giving a first-hand account of the reasons why changes were made.

EARL E. KLEINSCHMIDT, M.D.  
*Chicago, Illinois*

NOTE: A report on certain aspects of this study appears on page 483 of this issue.

#### HEALTH IN SCHOOLS—TWENTIETH YEARBOOK

American Association of School Administrators.  
544 pp. National Education Association, Wash-  
ington, D.C., 1942. \$2.

The responsibilities of the school administrator in the organization and administration of the school health program are described in this book. Emphasis is placed upon provision for individual health guidance of pupils, upon co-ordination of the instructional plan, and upon the place of mental hygiene in the life of pupils and teachers. The concept that "the whole child goes to school" has led to the growing appreciation that "the whole teacher works in the school." Considerable space is, therefore, given to the twofold responsibility of the administrator "to see that only teachers with the competence of health and vitality are added to the school faculties and that the health of teachers in service is protected and developed." In this connection, attention is called to reports from tuberculosis sanatoria which show "constant admissions of school teachers who have tuberculosis." Because of this, the National Tuberculosis Association has recommended that "teachers should be required to present annual evidence of freedom from tuberculosis. . . ."

The book contains a comprehensive chapter on Co-ordination of Health Agencies. Health is recognized as a

community problem which can be solved only by means of the concerted action of all related community forces. School health education thus becomes an integral part of the total community health education program. The school administrator is identified as one who may offer constructive leadership in effecting this co-ordination.

Altogether, in the opinion of the reviewer, this volume is the most significant expression of opinion on school health which has appeared since the report of the 1930 White House Conference and the School Health Studies of the American Child Health Association.

MARY E. CHAYER, R.N.  
*New York, New York*

#### EFFECTIVE LIVING

By C. E. Turner, Dr.P.H., and Elizabeth McHose,  
M.A. 432 pp. The C. V. Mosby Company, St.  
Louis, 1941. \$1.90.

Two well-known educators have presented this timely textbook for seniors in high school. The publication is most attractive and bears out the assertion of publishers that in no other field has greater progress been made in the format or style of books than in the textbook area.

Its content is very quickening because it focuses attention directly upon the purposes of education: self realization, economic well-being, human relationships, and civic responsibility. The book is divided into three parts, describing effective living for the individual, the family, and the community. In each part adaptation units present the material pertinent to the subject and each unit includes a self-checking list and suggested problems and activities.

Because textbook units can become monotonous and fixed in patterns, the high school today has either a curriculum committee or core-studies teachers who study inter-relationships, units most pertinent in meeting local needs, enrichment materials, and other factors.

Now that our country is at war, the

creative abilities of both teachers and pupils can be used not only to vitalize any or all of the 15 units included in this book, but may incline to add such units as, for example: Keeping Calm in Wartime, Housing in Defense Areas, Health Insurance, Population Problems, and Fitness for Winning This War. Some of the more gifted students may wish to co-operate with community agencies in making a survey of community health activities in wartime. The splendid up-to-date reference lists which conclude each chapter serve as excellent guides for carrying on projects which stimulate thinking rather than advocate fixed practice.

Health education developed in life situations, as promoted throughout this book, cannot help but inculcate the attitudes and habits of living which are so vital to our country today and tomorrow.

BESS EXTON  
*Washington, D.C.*

#### ADMINISTRATIVE MEDICINE

Edited by Haven Emerson, M.D. 839 pp. Thomas Nelson & Sons, New York, 1941. \$7.50.

This book is a compilation of the contributions of 56 authorities in organized care of the sick, public health services, and medical care for prevention and treatment.

Chapter X-B by Dr. Sara Josephine Baker, consultant for the United States Children's Bureau, dealing with school health service, is especially selected for comment. In a short chapter of five pages it is quite obvious that no adequate consideration could be given this subject. The author attempts to give a very brief history of the establishment of school medical services, the objectives and means employed to obtain them, and their achievements and failures as a whole. Some phases of the program which are deemed worthy of retaining and extending are listed. Emphasis is placed on the need for concentration of efforts on the correction of defects in the

preschool and entering-school groups, since here is found the highest incidence of physical defects.

The author states that "in all other parts of public health work preventive efforts have been successful," but that "school health supervision lags behind." This is not enlarged upon, nor is any program of preventive work suggested. The educational side of the school health services is not considered.

VERA BROOKS, R.N.  
*Newark, New Jersey*

#### THE HEARING OF SCHOOL CHILDREN

By Antonio Cioceo and Carroll E. Palmer. 77 pp. Society for Research in Child Development, National Research Council, Washington, D.C., 1941. \$1.

This monograph presents a detailed analysis and recommendations based on the results of hearing tests given to an unselected group of school children and repeated after five years.

The authors question the value of group testing for the purpose of screening out those who show no hearing loss, after comparing their findings with those from the pure tone test given individuals. The fact that a good prognosis for a hearing loss greater than forty decibels is doubtful points to the need for early detection of auditory impairment. Prevention and adequate care of middle ear infection are emphasized as important parts of the program for the preservation of hearing.

This excellent exposition should be carefully studied by all interested in the hearing program.

HELEN A. CARY, M.D.  
*Portland, Oregon*

#### NURSING

By Cecilia L. Schulz, R.N. 20 pp. Bellman Publishing Company, Inc., Boston, 1941. 50c.

This pamphlet should be in the hands of all school counselors and in all nursing school libraries. The material is derived from recognized sources. It can be used advantageously in programs for recruitment of student nurses. Miss Schulz

presents her material in an intriguing fashion. In her statement, "The field of the modern nurse has no fences, because preventive nursing applies to all human beings," she summarizes the progress from nursing the sick within four walls to promoting the health of all within our nation.

RUTH ADDAMS, R.N.  
*New York, New York*

#### MANUAL FOR MANAGERS OF RURAL AND OTHER SMALL SCHOOL LUNCHROOMS

Prepared and published by the Ohio Dietetic Association. 226 pp. Copies may be obtained from Mrs. Alice H. Smith, 1001 Huron Road, Cleveland. 1942. \$1.50.

This practical, comprehensive booklet will be most helpful to rural school lunchroom managers, but can also be used by those interested in church suppers and emergency feeding.

It includes information on the selection, preparation, and service of the lunch, the qualifications and training of personnel, the equipment and location of the lunchroom, food purchasing, cost accounting and sanitation, tested low cost recipes, and a bibliography.

Since the educational possibilities of the lunchroom are emphasized and the public health reasons for food sanitation clearly outlined, the material will be of particular interest to nurses working with school programs.

CATHERINE M. LEAMY  
*Alexandria, Virginia*

#### THE SCIENCE OF HEALTH

By Florence L. Meredith, M.D. 427 pp. The Blakiston Company, Philadelphia, 1942. \$2.50.

The preface aptly states that although "this volume is the second edition of *Twelve Hours of Hygiene*, the title having been changed with the change in scope and organization of the material," it "is virtually a new book, written for new times—grave times." It is "for use in one-hour-one-semester college courses in hygiene," but the reviewer's experience strongly suggests that the text is

suitable for a two-hour-one-semester course, especially if supplemented by a discussion of problems peculiar to the class at hand.

Each of the various health education specialists will find that his own subject has not been slighted. Due space is given to statistics, anatomy and physiology, nutrition, physical education, sanitation, bacteriology, first aid, drugs, diseases, mental health, and the next generation. This book will be an invaluable text for college hygiene teachers in helping students to live as well as to learn. Any public health nurse can find here many ways to improve her own life and many well-put answers to the questions asked her daily.

The new edition is shorter, more directly appealing, and almost conversational in tone. The author has condensed a wealth of material into a compact, attractive volume and, at the same time, has retained a gratifying freedom of style.

RAIDIE POOLE, R.N.  
*Superior, Wisconsin*

#### FOOD AND BEVERAGE ANALYSES

By Milton Arlenden Bridges, M.D., and Marjorie R. Mattice, M.S. 344 pp. Lea & Febiger, Philadelphia, second edition revised, 1942. \$4.

This completely revised edition is an excellent, comprehensive handbook on food values. The first part of the book gives food composition figures in terms of protein, fat, carbohydrate, and caloric content of common foods and special dietetic, strained, chopped or junior foods from various commercial firms. The remaining chapters discuss crude fiber content, purin content of cooked meat and fish products, metabolic reaction of foods, and mineral vitamin values of many common foods and beverages.

The detailed information and the listing of a large variety of foods under so many technical aspects of food values makes this a valuable reference for



physicians, dietitians, and nutritionists, who outline and calculate diets. Reference books that are less technical would be more useful to public health nurses

for general and comparative food values.

ANNA DEPLANTER BOWES  
Harrisburg, Pennsylvania

## RECENT PUBLICATIONS AND CURRENT PERIODICALS

### SCHOOL HEALTH

PRACTICES AND CONCEPTS RELATING TO CITY BOARDS OF EDUCATION. W. S. Deffenbaugh, Chief, Division of American School Systems, U. S. Office of Education, Washington, D.C., 1941. 27 pp. 5c.

STUDY OF CERTIFICATION OF SCHOOL NURSES BY STATE DEPARTMENTS OF EDUCATION. State of New Jersey, Department of Public Instruction, Division of Health, Safety and Physical Education, Trenton, 1941. Limited supply available on loan from the N.O.P.H.N.

SCHOOL HEALTH PROGRAM AND THE HOME. Reprint from Health Bulletin for Teachers. School Health Bureau, Welfare Division, Metropolitan Life Insurance Company Press, New York, N.Y., February 1942. Single copies free to school personnel.

Discusses closer working relationships between school personnel and parents.

A LIST OF SOURCE MATERIAL FOR TEACHERS OF COLLEGE HYGIENE. American Student Health Association. Edited by members of the Welfare Division, Metropolitan Life Insurance Company, 1942. Available through the Metropolitan Life Insurance Company, New York, N.Y. 46 pp. Single copies free on request.

Teachers of college hygiene will find this a useful guide to materials for teaching.

A USABLE DENTAL HEALTH INDEX FOR SCHOOLS. C. E. Turner, Dr.P.H., Percy R. Howe, D.D.S., and Marita J. Dick, C.P.H. *Journal of School Health*, January-February 1942. American School Health Association, Buffalo, New York. Single copy 25c.

Report of a study on an inexpensive and helpful index of dental health.

THE HEALTH SERVICES IN THE SCHOOLS. Bulletin No. 321. Eugene B. Elliott, Superintendent of Public Instruction, Lansing, Michigan, 1941. 31 pp. 25c.

School nurses, school administrators, and

classroom teachers will find this pamphlet useful. It includes recommended policies concerned with various aspects of school health service, such as the health of school personnel, accidents, medical and dental care, and the educational implications of these policies.

### WARTIME

PAMPHLETS available from the Office of Civilian Defense, Washington D.C.

The Civilian Evacuation Program: Policies and Principles. 6 pp.

The Civilian Evacuation Program: Planning for Evacuation and Reception Care. 53 pp.

CONFERENCE KIT BASED ON A WAR POLICY FOR AMERICAN SCHOOLS. Educational Radio Script and Transcription Exchange of the U. S. Office of Education, Washington, D.C. Available for loan free of charge.

WARTIME HEALTH PROBLEMS AND PROGRAMS. Four loan packets prepared by and available from the Information Exchange on Education in Wartime, U. S. Office of Education, Washington, D.C. Free for two-week period.

Wartime Health: The Problem. V-G-1.

Wartime Health: The School's Contribution. V-ES-1.

Wartime Health: Organization for Community Action. V-A-1.

Wartime Health: Malaria. V-G-2.

A PLAN FOR A VOLUNTEER NURSE'S AIDE SERVICE IN THE HOSPITAL. Prepared by a Committee of The New York City League of Nursing Education. Mary M. Richardson, Director of Nursing, Lenox Hill Hospital, New York, N. Y., July 1942. 22 pp. 15c per copy.

A useful manual to guide "those responsible for the training and supervision of the volunteer nurse's aides" in hospitals. Included are administrative plans for fitting the volunteer service into the hospital setup; authorized activities for aides; and suggested schedules for supervised experience of student volunteers.

# NEWS

## OUR MOST PRESSING PROBLEM

THE National Nursing Council for War Service is urging the formation of committees of supply and distribution of nurses by all state and local nursing councils for war service. Distribution of nurses to meet military and civilian needs is the pressing problem of the moment, and there is necessity for immediate community planning that *works* and makes adjustments to meet Red Cross quotas for military service and to relieve drastic shortages in hospitals.

Successful planning is being done in some communities. Distribution of nurses is being made on a community basis. In emergencies, private duty nurses and other nurses are relieving in depleted hospitals till readjustments can be made. Urgent needs of sick patients are being met. If the nursing profession is to retain direction of its own services, this kind of planning must be done, and done speedily, throughout the country. Public health nurses have a responsibility to do their share, the Council believes, in seeing that committees are organized and functioning actively in regard to this problem at the earliest possible moment.

## COUNCIL STAFF APPOINTMENT

MARGARET S. TAYLOR was appointed to the staff of the National Nursing Council for War Service in August to assist in the clearance bureau of the National Committee on Recruitment of Student Nurses. Miss Taylor has been with the Visiting Nursing Association of Buffalo, N.Y., as educational director and has also served as administrator of the public health nursing program and assistant professor of public health nursing in the University of Buffalo School of Nursing.

## ARMY TAKES OVER HOSPITAL

THE American Red Cross-Harvard Field Hospital Unit in London has been taken over by the Army for the duration of the war, and will be the central laboratory for United States armed forces in Great Britain. At the end of the war it will be turned over to the British Ministry of Health.

This field hospital, which was opened in 1941, has been operated jointly by the American Red Cross, Harvard University, and the British Ministry of Health, for the study and control of wartime epidemics. The Unit has a staff of 85 physicians, nurses, and technicians. It consists of an epidemiological field unit, a well-equipped laboratory, and a hospital of 125 beds.

The work of the public health nurses who are a part of the Unit staff has been described in several letters published in this magazine during the past year.

## HOME NURSING CLASSES

AN impressive record of accomplishment in Red Cross Home Nursing classes is found in the annual report of this activity, just released. In the spring of 1941, a request was made for 15,000 instructors. By the end of July, 31,000 had responded and had been authorized to teach—of whom more than 60 percent were inactive nurses. Nineteen thousand of the 31,000 have already taught classes.

In the Midwestern states, 22 percent of the instructors were public health nurses. Many of these were full-time nurses who crowded their teaching into days overburdened with increased duties. In most cases the nurses or their agency volunteered the time as a contribution to the war effort. Only four percent of the

teachers were paid by Red Cross chapters and most of these devoted their full time to the classes.

During the past year, 396,214 people completed the course in home nursing—372,674 since Pearl Harbor. Interest is steadily growing. In December, there were 570 classes; at present, approximately 4000 classes are being taught. However, a big job remains. There are still large areas where Home Nursing classes are not available. Only 66 percent of the Red Cross chapters have classes. The ultimate aim is to have one person who has completed the Home Nursing Course in every home where it is practicable.

#### PLANS FOR INCUBATORS

THE Children's Bureau has available a new supply of blueprints for building two types of incubators and a carrier for premature babies, which were prepared by the National Youth Administration and the Children's Bureau. (See PUBLIC HEALTH NURSING, May, 1942, page 244.) If copies have been requested and have not been received, an order sent to the Children's Bureau, U. S. Department of Labor, Washington, D.C., will now be filled promptly.

#### VISITING NURSE IN ENGLAND

"INVASION and the District Nurse," by John C. Hodgson, M.D., Home Guard Group Medical Officer, appearing in *Nursing Times*, April 18, 1942, journal of the British Royal College of Nursing, states in a matter of fact way what the district nurse should do, come parachutes and gliders carrying enemy troops.

The threat of invasion, which is ever with us, will assume more menacing proportions in the near future. If invasion does come the initial attacks will be carried out by air-borne troops. It has been estimated that 1000 gliders, each carrying 12 men, are capable of landing in an area of  $4\frac{1}{2}$  square miles. Such a considerable force would certainly dislocate the entire casualty services of the surrounding district.

Isolated country areas are considered the probable scene of such landings, and for that reason most of the following remarks apply more to rural than to urban areas. Although the latter have at present well equipped civil defense posts and hospitals, these form easy and obvious targets for the Nazis, who observe no rules of warfare. For this reason what is at present not strictly applicable to towns might easily become so at a later date. In both areas civilians as well as combatants may be cut off from all specialized medical help for days and, therefore, what is a medical necessity in rural areas must not be considered redundant in towns.

The district nurse may well be the only trained nurse in the area and should therefore be prepared to give all the help possible. What can she do to help in this scheme?

For the present she should: (1) get in touch with the local home guard doctor or platoon commander and offer her help, if she has not already done so (2) call on those householders who have casualty collecting posts on their premises, and advise them on how to make the best use of their available space and equipment (3) enlist the help of the local population. She can by her enthusiasm do excellent propaganda, more especially among that section of the community with whom she is in closer contact than any other person. She should (4) select her helpers, allocate their duties and advise them, teaching them elementary first aid and home nursing. She should (5) make contact with the Women's Institute and the woman's voluntary services organizations in her district. She will find that both will give invaluable help in making bandages, palliasses, pillows, and other first-aid equipment.

When invasion comes she should: (1) act as the medical officer's chief assistant (2) assume control in his absence (3) supervise and help the personnel of the posts in her area (4) uphold morale (5) exhibit *triage*. This is a word coined by the French, the definition of which is—the correct diagnosis classification, sorting, and labelling, and the dispersal of wounded in the correct surgical priority. Further explanation is obviously unnecessary.

In this short survey I have attempted, firstly, to explain the scheme initiated in this country by the home guard medical service based on the realization that, although our casualty services were most highly developed against blitz, no parallel degree of organization existed to meet invasion, and secondly, to show how the professional ability and experience of the district nurse can best be utilized for the public good within its framework.

• The Conference on Venereal Disease Control Needs in Wartime will be held at the Arlington Hotel, Hot Springs National Park, Arkansas, October 21-24, under the auspices of the U. S. Public Health Service, in conjunction with the Eighth Annual Meeting of the American Neisserian Medical Society.

• "Now that we are at war we are fortunate in having this rich resource of recreation to give us physical, mental, and spiritual power for the titanic task at hand," says the President of the United States in a letter sponsoring the War Recreation Congress to be held by the National Recreation Association in Cincinnati, Ohio, September 28 to October 2. A program of group discussions covers a score or more of topics—recreation for special groups such as women in industry, teen-age girls, Negroes, villages and small towns, and many others.

• Among the annual state meetings to be held in the fall are the following:

California State Nurses Association, Fresno, October 2-4.

Connecticut State Nurses' Association, New Haven, November 5-6.

Kansas State Nurses' Association, Wichita, October 6-8.

Pennsylvania State Nurses' Association, Reading, October 19-20.

West Virginia State Nurses' Association, Parkersburg, October 15-17.

Wisconsin State Nurses' Association, Madison, October 3.

• The 31st National Safety Congress and Exposition to be held by the National Safety Council in Chicago, October 27-29, will emphasize the part of accident prevention in winning the war, and the effect which accidents have in delaying war production. Following a proclamation by President Roosevelt the Council is now conducting a greatly expanded wartime pro-

gram. Five million dollars will be sought to meet costs. New executive vice-president and managing director is Ned H. Dearborn of New York City.

• The American Dietetic Association will hold its twenty-fifth annual meeting at the Hotel Statler in Detroit, October 19-22. Best methods of teaching nutrition to the public will be emphasized, and the most effective means whereby dietitians can help the Red Cross. The sessions are planned "to provide the dietitian with the greatest possible aid in playing her part under the difficult circumstances imposed by the war."

• The U. S. Civil Service Commission announced on July 7 unassembled examinations No. 240 for junior public health nurse at \$1800 a year; No. 242 for public health nurse at \$2000 a year and for graduate nurse, general staff duty, at \$1800 a year. Applications will be accepted until the needs of the service have been met. Graduation from high school is no longer required for the public health nurse or graduate nurse. Registered nurses with appropriate nursing education and experience may apply. There is no maximum age limit. Full details including application forms may be obtained at first- and second-class post offices.

#### NEW APPOINTMENTS

The United States Public Health Service announces the following assignments to the National Institute of Health, Bethesda, Maryland, for the orientation program:

##### *Public health staff nurses*

Mrs. M. Irene Walker Bannister, Mildred S. Benjamin, Helen Canfield, Mrs. Nancy G. Davis, Elizabeth Dills, Mayche A. Eggleton, Rose V. Fortuna, M. Estelle Hunt, Dorothy V. Jansen, Estelle M. Jung, Emily J. Knotek, Opal Elizabeth Lewis, Anna Theresa McMahon, Carol Martin, Ella Helen Moser, Lera Neill, Mrs. Virginia P. Osborne, Joyce Quinby, Betty Ruth Ranson, Eleanor M. Schollaert, Mrs. Katherine M. DeYoung Van Bree, Edna W. Venberg, Romaine Wicks, and Myrtis Hall.

##### *Male staff graduate nurses*

William D. Hill and William Rosen.

# Why the Cinderella of stars in today's Nutrition

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1. Margarine became different in texture and flavor when vegetable oils such as cottonseed and peanut were substituted for old-time animal fats. NUCOA was the leader in making this improvement.
2. Margarine was Americanized. Here, too, NUCOA took the lead. It was the first margarine to use only oils and skim milk produced on American farms exclusively.
3. Margarine gained nutritive value through addition of Vitamin A. NUCOA was the first margarine to add precious, protective Vitamin A.



**Where does Nucoa fit into the "Nutritional Yardstick"?**

The nutritional program for every day calls for "butter and other spreads" that are vitamin-rich. NUCOA's value in making this program practical in the home is twofold:

1. NUCOA furnishes an amount of Vitamin A that is dependable at all times—never less than 9,000 U.S.P. units per pound. This, according to the U.S. Dept. of Agriculture, is the average for butter, which varies considerably pound by pound.
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**Have you personally tasted and used Nucoa?** As a spread for bread, for seasoning and shortening, for frying—NUCOA is "good nutrition" and good eating. It is always sweet and fresh, for it is freshly

## Nutritious NUCOA

ONE OF AMERICA'S GOOD "PROTECTIVE VITAMIN A" FOODS



# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## What Progress Have We Made?

**W**HO SHALL go and who shall stay? Where am I most needed? How can my service be used to greatest advantage in this war? These questions, which each individual nurse must answer, lie at the heart of the whole problem of effective distribution of nurses to meet the country's needs. Our efforts to date have been only partially effective. During September, the National Nursing Council for War Service and its committees of nurses drawn from all over the country met in busy session to plan ways of giving more concrete help to states in maintaining adequate nursing service to civilians while supplying the military service, and at the same time preparing sufficient nurses for the future.

More specific help than has yet been given is requested by nurses and organizations in the field. Nurses who should serve with the armed forces and those who should stay at home to meet civilian needs are listed in categories in the Council's widely used pamphlet, "Nurses, to the Colors!" Useful as this list of categories has been, it has raised further questions. For example, public health nurses under 40 who are single and "not essential for maintaining minimum civilian health service in any given community" are designated as those who should serve with the military service. "What," they ask, "is a 'minimum civilian health service?'" How are we to know whether we are essential?" Obviously, further definition of these categories is required.

The Council allocated to its member agencies most concerned with the various

categories the task of preparing more specific instructions for their application. The National Organization for Public Health Nursing started immediately on this task. The definition of what constitutes "minimum civilian health service" leads at once into the whole question of what are criteria for determining whether nursing service is adequate in amount and kind. Some criteria for public health nursing services are given in the Council's guide, "Distribution of Nursing Service During War." This handbook would be immensely helpful if more widely used. But in addition, help is needed in knowing quite specifically in the light of accepted clinical procedure for each type of nursing service—be it maternity, tuberculosis, child health, or orthopedic—what nursing activities are most important to keep as they are, what ones need to be modified, and what ones may be eliminated during the emergency. Nurses are asking also what corners can be cut without hazard to health of patients; how professional skills can be most effectively used, and where other personnel can be substituted; what techniques are labor-saving in terms of professional service.

Use of auxiliary personnel in all branches of nursing to an extent not heretofore approached came in for careful discussion. A recent communication from the Surgeon General of the U. S. Public Health Service to the executive secretary of the Subcommittee on Nursing, asked for measures to implement the program for auxiliary nursing service above the housekeeping level and offered

*(Continued on page 597)*

## *Editor's Farewell*

THE PERIOD of almost seven years during which the retiring editor has served this magazine and the N.O.P.H.N. has seen the country apparently emerging from the depression only to be plunged into war. The pages of the magazine during these years reflect certain social gains for which public health nurses have long hoped and for which many have actively worked. They reflect, alas, many other unmet social needs which have as yet been barely touched.

Medical and nursing care of the needy sick, which became an acute problem in 1935-1936 with discontinuance of governmental payment for care of patients on relief, is today in most communities scattered among a variety of agencies, with the result that many patients receive little if any care. (See page 556 of this issue.) And the National Health Program, with its bright hope for a new day in the reduction of illness and provision of medical care for the people, is indefinitely postponed. Care of low-income families through prepayment plans for distribution of costs has received widespread experimentation in these seven years. The inclusion of nursing in prepayment plans is, we hope, a next development.

Acceleration of public health programs in rural areas and progress toward governmental responsibility for the health of its people followed passage of the Social Security Act in 1935. Improvement of health facilities under this program, including emphasis on special needs of certain groups such as mothers and children and crippled children, is recorded in articles during recent years. These services mark a modest beginning in a program of public medical care. Better qualified public health personnel prepared through allo-

cation of Social Security funds to states for stipends, and later through development of merit systems of personnel administration, is an indispensable part of this progress. Redefining and changing of private agency functions to meet new or hitherto unmet needs are seen in magazine discussions of relationships between nonofficial and official agencies and in articles on growth of citizen advisory groups to insure high standards of service in governmental agencies.

Increased power of labor as a group in the national life and increasing industrial hazards due to the new technology have been accompanied by recognition of the importance to industry and the community of healthy workers. Recent growth of industrial programs, particularly in small industries where the nurse is the only full-time health worker, has resulted, together with new plans for giving service to these industries. (See page 550.) Greater participation in and control of these programs by the workers themselves are just emerging. Concomitantly, public housing projects to replace slums as homes for workers were just beginning to make headway in 1939-1940, as described in several articles in our pages. These are a casualty of the war, which has brought the worst housing problems in our history, and realization of long-time housing plans awaits the postwar period.

Interest in provision for the old age of nurses, discussed in 1936-1937, was a part of the trend toward providing economic security for all—security which is no longer possible for most people through individual effort alone.

Social planning, which in its broad sense means economic planning to remove the causes of war and social maladjustments, recurs in recent articles.

*(Continued on page 590)*

# Mental Hygiene in Industry

By EUGENIA S. CAMERON, M.D.

**A**NY PROGRAM to promote the health, safety, and efficiency of industrial workers must consider *mental* health, because the health problem is a problem of *persons*, in whom body and mind are inextricably working together. Emotional attitudes of individuals in industry, whether they be workers or supervisors, nurses or doctors, or the management itself, are just as important as their physical health and their conditions of work.

Now more than ever, efficient productivity is vital to our existence. Every man is precious to the life of the nation and anything that is done to make him more effective in his work is a direct contribution to the war effort as well as to the happiness of each individual worker.

Estimates based on recent figures show that an average of eight percent of working days are lost—two percent from industrial accidents, two percent from illness and nonindustrial accidents, and four percent described as “avoidable time lost.”<sup>1</sup> A year’s work time of one million men—340,000,000 work days—is lost each year.<sup>2</sup> Now with the employment index rising we can expect even greater absenteeism because marginal workers are being drawn into industry. These persons will need to be trained, and in that process there will inevitably be more accidents. The tempo of production is accelerated. Emotional tension is high. Fears and anxieties are common. All the conditions are right for increased work problems. Many of the men who are coming back into industry have been considered unemployable for long years and will need to be mentally and socially rehabilitated. These problems require the application of prin-

ciples of rehabilitation in relation to both physical and mental health.

Mental hygiene is a phase of preventive medicine which seeks to eliminate the emotional maladjustments that handicap individuals and so keep them from operating effectively. Its goal is the achievement of mental health, a state which has been described as a “harmonious and efficient organization of the total personality, so that it is able to adjust itself well to its environment and to maintain a suitable emotional balance in situations that arise.”<sup>3</sup>

## MENTAL ILLNESS WIDESPREAD

Mental disorder of varying degrees accounts for a large proportion of avoidable absences from work. Poor mental health interferes with a person’s normal functioning and incapacitates him from adapting to the demands of his life. The number of persons who are mentally ill in this country is very large. Five percent of the population some time during their life span spend time in a psychiatric hospital because of a severe breakdown. A study of Selective Service examinations made by local boards up to May 31, 1941, showed that 6.3 percent of the rejections of young men were due to nervous or mental causes.<sup>4</sup> Many of these men will find their way into industry. They will have to be fitted somehow into civilian life.

More numerous yet are those who suffer from less severe difficulties. Conservative estimates by private practitioners state that thirty-five to forty percent of the patients coming to them with body complaints really are suffering from emotional difficulties which underlie their organic disorders.<sup>5</sup> These men are losing time out of industry because of

poor adjustment. They are perhaps the most difficult problem for industry. Nearly ninety percent of industrial accidents have been ascribed to emotional factors by Dr. Lydia G. Giberson, who has contributed so much toward a better understanding of these problems in American industry. Certain workers are more prone to accidents and illness than are others. In a Metropolitan Life Insurance Company study, less than two percent of the workers were found to be responsible for thirty percent of the accidents. In another industrial study it was discovered that thirty percent of the workers made seventy-five percent of the total visits to the dispensary. They are the repeaters. These persons are also the ones who caused most complaint and personnel problems. They were responsible for more traffic violations, committed more misdemeanors, and had more marital difficulties than the average worker.<sup>7</sup>

#### WORK PROBLEMS ARE SYMPTOMS

What does all this signify? It seems to mean that the accident problem and the absentee problem are actually problems of total personality adjustment. They seem to be symptoms of all-around difficulty in meeting the work situation adequately, in persons who are having other symptoms as well. Poor quality of work, an unsatisfactory mental attitude, and friction with other employees which cannot be traced to the commonplace events of everyday working conditions should lead one to suspect severe nervous and mental strains from any one of a number of causes.<sup>8</sup> These poor work adjustments must be recognized as health problems that fall within the scope of the nurse's work.

Employee problems include accidents, absenteeism, quarrels, chronic fault-finding, blaming others, bullying, sensitiveness, resentment of criticism, overdependence, getting upset by changes in routine, inattention, daydreaming, se-

clusiveness, and worrying.<sup>9</sup> We must look upon these as symptoms of a personality disorder. The worker's adjustment is determined by his total personality, his physical condition, his intellectual capacity, his past experiences, his present situation, his emotional life, and his attitudes. If his reactions are to be understood, the physical, mental, emotional, and social aspects of his life must be known. Behavior is purposive. It is the individual's way of trying to satisfy his desires.

#### WHAT CAN INDUSTRY DO?

Is there any way men and women can be kept on the job working efficiently and well so that poor adjustment may be avoided? Can industry do anything to help in this direction? Perhaps it can, with a clearer understanding of how men adjust. Why do they fail? What are the early signs of failure?

When a man comes to work in the morning he is not merely a worker. His total personality comes to the job. He is a husband, perhaps a father. His health and activities outside the factory definitely affect his work. He brings with him to the factory the worries of his home life. His inattention on the job, his poor production, or his accident may possibly be accounted for by these outside factors. Fatigue and monotony in work lower the level of his concentration and allow distracting thoughts to occupy the worker's attention. Troubling preoccupations in turn increase fatigue. Energies that are dissipated by a worker in a fruitless attempt to solve personal problems are lost. His emotional tension exhausts him.

Every person meets problems in all the stages of his existence. His effectiveness depends upon his ability to solve these problems successfully. Of course, some individuals get more than their share, and break down because of the excessive strain. But every person finds that life requires him to modify his de-

sires, hopes, and dreams in adjusting to the reality situation. The way in which he is able to meet frustrations and compromise in the face of restrictions and requirements determines to a large extent his mental health. Substitute satisfactions must be accepted, goals must be modified. His happiness and contentment depend upon his ability to make these adjustments, and to handle situations successfully. In order to understand why workers fail and how we can help them, we must know what their fundamental needs and desires are. We must see how life and the job meet or do not meet those needs.

The key to understanding is remembering that *all* of the personality goes to work—not just the brain or just the brawn. The emotional part of the man's total life affects his work. If he quarrels with his wife in the morning his work will be affected. Unaccountably that day he may flare up at some criticism he ordinarily could take without a word. His experiences at work influence his behavior at home. A man who has had an especially hard day at the shop finds he is supposed to go out to dinner at his mother-in-law's. He objects out of all proportion to the immediate incident, and without realizing it, takes out on his wife his resentment at the foreman's fussiness and the day of strain.

#### ALL HAVE NEED FOR SECURITY

A fundamental need of all persons is the need for security. This is a feeling that comes to one when he is accepted and belongs. Most naturally this kind of security arises in the family unit, where one is accepted just because of *who* he is—a member of the family group. To be accepted and loved in childhood contributes a great deal to emotional stability throughout life. The fortunate man with happy home life and congenial wife can take the buffetings and uncertainties of industrial life with much more equanimity than the man

who is alone or has a shrew for a wife. Present migration of workers into industry, away from their homes, will have its effect on their sense of security, as it will also affect the sense of security of the wife and children left behind because of crowding in the factory area. How is this sense of security going to be built up in the children of working mothers? Women in industry will be inefficient unless they know the children they have left at home are being cared for adequately.

The question has been raised as to whether workers can get something of that sense of security from the developing family pattern in industry, as exemplified by the paternalistic benevolent arrangements in increased social securities.<sup>10</sup> A man cannot feel his special skill guarantees him recognition and a place in the factory where mechanization has been introduced. He knows he can be easily replaced. This fear of unemployment, especially in older persons, plays a great role in disturbing work efficiency.

#### SENSE OF ADEQUACY IS NEEDED

Another fundamental need of every human being is the need for a sense of adequacy, a sense of being accepted because of what he can *do*. In industry it is difficult to give a worker the sense of fulfillment that comes from creative work as an end in itself. The era when a man could point with pride to the product of his own hands is past. Many workers carry through a process with no conception of its place or importance in the final product. They are satisfied with the quality of workmanship, if it manages to slip by the eyes of the inspector. Any way in which a worker can be given a sense of his place in the scheme of things and some realization that his work is truly essential will contribute to his sense of adequacy and give him satisfaction. We see that principle tried in the awarding of the Navy E and of



buttons to individual workers who have done a good production job. The premium now being put on the importance of each individual worker's job in all our propaganda achieves the same end.

Work is too frequently just a way of earning a living. For many, it is a way of securing the wherewithal with which to buy their satisfactions elsewhere. Yet a third of each man's life is spent at work. A man needs an occupation for which he is fitted, in which he can gratify the need to achieve. A person set to do a task that does not make use of his capacities becomes bored and inattentive, mechanically performs a monotonous job. Worries about home life intrude themselves because he is not absorbed in the work. He fatigues easily, and is accident-prone.

On the other hand, the man who is put on a job requiring more ability than he has will break under the strain. Because a worker performs a simple process well he may be advanced to a job that requires him to take greater responsibilities, to direct others. If he is unable to do well at it he may begin to show manifestations of breakdown, and we may get so-called "promotion depression." The worker feels incompetent. He has trouble in sleeping, loses his appetite, shows weight loss. He becomes fatigued, has difficulty in concentration, is self-depreciatory, worries about his ability to hold his job, begins to feel life is not worth living, and has suicidal thoughts. Then we have a mentally ill worker.

So it is essential to find the right job for a man. Taking his measurements by means of tests is only part of fitting him to a job. Intellectual capacity and skill in a technique are not as important as personality characteristics in determining success. If the worker does not adapt easily to change, an advance may be the worst thing that could happen to him. If he feels inadequate, he may break down under the strain.

Another common way in which inade-

quacy on the job affects a worker is by causing what is called a "flight into illness." With tension at work, physical symptoms develop. Anxiety is translated into organic symptoms. Palpitation, sweating, rapid pulse, pain in the cardiac region, a condition simulating anginal attacks may develop. Or the locus of trouble may be in the gastrointestinal tract—a lump in the throat that prevents swallowing, nausea and vomiting, or diarrhea. These are the patients who fill the ranks of the thirty-five percent in the doctors' offices. They are really upset physically though the original cause is their feeling of inadequacy. A "flight into illness" saves a man from admitting to himself that he is not capable of handling a job. His illness gets him out of the situation, for organic illness is an honorable excuse for failure. He will not get well until his work situation is changed, but then he may recover rapidly.

Another type of behavior that arises from inadequacy feelings is overcompensation, as for example, the bossy, domineering foreman who insists on minute obedience. An epidemic of trouble in a department can often be traced to such an individual.

#### DESIRE FOR SELF-EXPRESSION

A person identifies himself with the group to which he belongs and ascribes to himself the qualities and strength that the organization stands for. He needs to feel accepted by the group, and recognized by its members as a person. Self-expression is satisfying. If a person feels isolated and alone, he tends to withdraw from the group situation. He may take refuge in daydreams in which he can satisfy his longings. There is no check with reality situations, and the fantasies may become so satisfying that he loses interest in real life, is inattentive at his job. He becomes inefficient, cannot co-operate, withdraws, may become seclusive and truly mentally ill.

Sometimes a worker who feels left out of the crowd solves his situation by rationalizing to himself and saying that the rest of the group is inferior to him, is lowbrow. Or he may try to win his place by boasting, by conspicuous attention-getting behavior, or by psychopathic lying.

#### SOCIAL RELATIONSHIPS IMPORTANT

The very great importance of the social relationship in industry was brought out in a series of studies made by the Western Electric Company's research staff.<sup>11</sup> Social relationship was found to play a greater part in productivity and adjustment on the job than did physical working conditions. These experiments are so interesting and have such far-reaching implications that a review of them is worth while.

Originally the Company's prime interest was in determining the effect of certain physical conditions of work on output. They chose intensity of illumination. They set up a situation in which the only known variable was the light. However, they could find no simple relation between illumination and output because it seemed impossible to isolate that one factor from other factors determining efficiency. One of those other factors was the psychological one. They found that the workers were reacting to the change in light intensity as they thought they were *expected* to react. If illumination was increased, they produced more. If it was decreased they produced less. When bulbs were changed but the same intensity maintained, output still increased if they believed the new bulbs were of higher power than the old. This psychological factor was a disturbing one in the experiment, but very revealing for an understanding of the importance of attitudes to work output.

Another study was undertaken to analyze the effects of rest pauses on working efficiency. It was hoped that

the psychological factor would disappear if the experiment was prolonged. Then the changes themselves, in pure culture as it were, could be studied. A small group of average workers was isolated by a partition from the remainder of the workers performing the same task of assembling telephone relays. Records were kept of everything in the physical environment and of a great deal in the outside environment. Weather conditions, and the temperature and humidity of the test room were all recorded. Principal events that occurred during the course of the day were set down, and conversation that was carried on. Hours of rest at night, food eaten, and home activities were also noted. Output records, rejections of articles produced, and the time of day at which these occurred were kept track of.

Before the experiment was started the girls were interviewed and the purpose was explained to them—that the Company was interested in studying the effect of conditions of work on output. They were not expected to try to make a record, but just to work at their ordinary pace. Whenever any change in routine was contemplated in the course of the experiment, a conference was held, the reason for the change explained, and comments requested. If a proposed change was not acceptable to the girls, it was abandoned. Basic production level was determined by a period during which work conditions were left just as they had been in the rest of the division.

Then a sequence of changed conditions was studied. First, five-minute rest periods were given, one in the morning and a second in the afternoon. Ten-minute rest pauses were instituted later on. Then six five-minute rests were given during the day. Later, a light lunch and rest morning and afternoon were initiated. Still later, the same procedure was followed, with the work day cut down by half an hour, then by an hour. A return to the regular work day

length was then tried out. A five-day week was studied. Throughout all of the changes, the daily output curve rose slowly and steadily. Even when a return was made to the original conditions of work, the same as those in the control period, there still was an increase in daily output. Obviously there was no simple relationship between any of the physical conditions of work and the output.

#### MENTAL ATTITUDE AFFECTS OUTPUT

The girls themselves, in accounting for the increase in output, said that it was just because "it was fun." They also said they felt freer because they were not supervised. Actually they were being observed very closely and they were aware of it. But the character and the purpose of the supervision were different from what they had been in the factory proper. The interest of the Company in the experiment and the inclusion of the girls in the planning contributed a share in raising output. Within the group a social development occurred, affecting production and social relationship outside the factory as well. There was only one thing that showed a continuous relationship to improved output and that was the mental attitude of the operators.

The National Research Council's Committee on Work in Industry reviewed this and other studies and stated that "the most important result of investigations of this kind seems to the Committee to be the proof that the individual is powerfully actuated by a desire for an intimate and routine relation with his fellow-workers, a desire which when satisfied makes for well-being, when unsatisfied for distress, and this desire leads him to subordinate his own material interests and his own independent thinking. . . . This surely is a characteristic of all society and particularly of all stable society."<sup>12</sup>

If the individual's own reaction to situations determines how well he is

going to do his work, we must know what his attitudes are in order to discover the causes of his difficulties and be able to help him. Those persons having difficulty will seek help themselves, or will reveal their poor adjustment by their accident- and illness-proneness or the trouble they cause in the plant.

The Metropolitan Life Insurance Company carried out interviews with all employees who were reported as having personality clashes, disaffections, inexplicable loss of efficiency, excessive fatigue, accident repeating, and avoidable absenteeism, and succeeded in preventing many of these problems from recurring.<sup>13</sup>

In the Western Electric Company the problem of excessive illness was confined to a relatively small proportion of the entire plant population. Of 12,000 employees, 1600 were sickness-prone. These were selected as the group on which to concentrate efforts because it was believed healthy persons give health no real thought. Persons with experiences of sickness are found to be much more receptive to health education. After a thorough physical examination of this group, their repeated illnesses were discussed with them. Interviews were repeated and problems discussed as they arose. As time went on it was found that this formerly sickness-prone group showed less illness than did the control group.<sup>14</sup> The individual's illness record led to a study and treatment of his whole self, not just his immediate complaint. So often the symptom itself is merely an unconscious expression, through illness, of disappointment in work or in home life.

#### VALUE OF INDIVIDUAL INTERVIEWS

A plan for individual interviews with workers as a means of understanding them better and helping them with their adjustment has been established in some industries. For years this method has

been used to select personnel for positions. At first applicants were placed in jobs on the basis of tests alone. Soon, because of the number of failures of persons who were thought to be placed in just the right niches, it became obvious that more than tests was necessary. Vocational aptitude, mechanical skill, or high intelligence cannot guarantee good performance. The total behavior pattern has more to do with determining success than have these other factors.

The personality pattern reveals itself most clearly in a history of a person's past experiences, his work record, and his emotional attitudes. A history of many accidents, of recurrent vague illnesses, or of many job transfers should indicate to the interviewer that there may be a personality problem present. In times when men were overabundant and work scarce, the applicant was turned down for the job. But even though he was rejected by industry he could not be rejected by society and thrown out on a human dump heap. He had to go on living somehow. Possibly careful planning for him and with him could have led to more successful adjustments, and fewer unemployables.

Now we do not have that choice. We must accept the less perfect specimens and we must somehow work with them so we can keep them performing efficiently. "There is a very real need," according to the Committee on Work in Industry of the National Research Council, "for an impartial, nonauthoritative agency whose function is that of interviewing employees, diagnosing their problems."<sup>15</sup> Where is that agency to be found? These persons, in whom the need is greatest, come to the industrial nurse in many instances because they are the accident-prone and the sickness-prone. They fill the waiting room, seeking aid frequently. Because of the nurse's professional position and because of the prestige of all things medical, they

are ready to accept her as a confidante.

If the nurse is herself emotionally mature and experienced in human relationships she can do a great deal to help these employees. She must maintain a proper balance between her personal feelings and the objectivity without which she cannot evaluate a problem. If she herself becomes emotionally involved, she cannot remain clear-eyed enough to help find solutions. On the other hand, if she identifies herself as a representative of authority she will see the worker's inadequate behavior, his injury, his illness, his quarrels only as annoying disturbances disrupting the smooth running of the plant. Her attitude becomes one of sitting in judgment, and she sees the worker's behavior in terms of "badness" or "meanness," rather than as the result of his attempts—albeit poor attempts—to adapt himself to his total situation.

#### TALKING THROUGH A PROBLEM HELPS

The interview experience itself does something for the worker. In the Western Electric Company plan they seemed to "enjoy the opportunity of expressing their thoughts. They felt some kind of release, as if feelings which had long been pent up within them had at last found an outlet. . . . Exaggerations, distortions, emotional reactions, defenses are largely dissolved when thus viewed objectively." In a similar way, employees who express their thoughts and feelings to an impartial listener have emotional release. "Many personal and individual problems and attitudes have been improved by the verbal expression which the interview affords."<sup>16</sup>

The opportunity to express anxieties is helpful to the worker. Sometimes his thoughts will gravitate back again and again to a particular topic. This is a sign to the interviewer that the worker's preoccupation with this subject is important to him, that it has significance in determining his behavior, even though

the topic may seem trivial. It is the worker's attitude that is important and not the listener's evaluation in terms of her own life experiences. Reiteration of troubles, however, is constructive only when the worker is eased by the talking.

Talking through a problem helps in thinking it through. The worker himself becomes more objective and can see things less emotionally. Authoritative advising and an "I-would-do-this-if-I-were-you" attitude fails. The worker must formulate his *own* plan of action if he is to be able to carry it out successfully. It must come out of the background of his own past experience, helped by the objectivity of the present experience of thinking it through.

#### CARE OF THE ACCIDENT-PRONE

The accident-prone will also be among the nurse's regular visitors. Sometimes it almost seems as though they put themselves in the way of accidents. And perhaps they unconsciously do. Individuals who are getting no satisfaction from their work certainly recover from injuries more slowly. Their speed of recovery is determined less by the severity of the injury than by their reaction to the experience. The pattern of reaction to illness or injury is set by a person's previous life experience. If as a child he enjoyed his illness, was pampered when sick, and relinquished slowly the privileges granted him, he may take a longer time to recover from sickness in adult life. A person who is unhappy in his work situation, getting no recognition when he is well, becomes the object of concern and sympathy when he gets sick or is injured, especially if management has feelings of guilt because the accident was preventable. Many a husband gets love and devotion only when he is ill. The attention-starved, the affection-hungry, the inadequate person recovers slowly if his illness brings satisfaction he can get in no other way.

When a man is injured it is essential

that *he* be treated, and not his wound alone. The way he is handled from the minute of injury determines his attitude toward the experience, toward his employers, and toward the future. The very first contact with him is the beginning of psychological and physical treatment. From the bearing and facial expressions of the people who surround him, his fears may be allayed or increased. He is frightened, ready to misinterpret every word and gesture. Medical terminology designed to conceal from him the state of affairs scares him to death. The word "laceration" sounds like a fatal disease, while "cut" is within his realm of understanding. He fears crippling, dreads mysterious treatment, worries about the effects of the accident on his economic situation.

The nurse is in a position to clarify things for him. Nothing is gained by minimizing the pain to be expected, but emphasis on the good that may be expected from the painful treatment makes him able to endure it more readily. Some workers, the ones that regularly overcompensate, will want to be thought tough and hardy. They want to show they can "take it." They cover up their fears by false optimism and even gaiety. If we take this attitude at its face value we will tend to exaggerate the seriousness of the situation in order to impress them and thereby create anxiety.

In planning for immediate care and future rehabilitation the industrial nurse must use a variety of community resources. But the personnel of the other agencies have not necessarily known the worker before. Close co-operation will promote better understanding and wiser management.

Return to work at the earliest possible moment is part of sound mental hygiene for the injured. Occupational therapy translated as soon as feasible into real work activity is the most constructive kind of handling. Even if work must be part time or at a less skilled level it is



important to rebuild in the patient the concept of himself as a worker.

The integration of a poorly balanced personality may be severely upset by accidents. Sometimes a worker is made overdependent. He expects and gets special privileges for years because of an injury. When accident compensation is involved, the sooner monetary settlement is made the better. Lump-sum settlements may cure a long-drawn-out disability. It is often very difficult to differentiate between malingering and a true traumatic neurosis. Unsettled financial compensation confuses the issue. It may even start a paranoid development with years of litigation, in a suspicious person who may have felt for a long while that life in general and management in particular had not been giving him a square deal. Depressive symptoms with self-depreciation and feelings of hopelessness and anxiety may follow an accident, especially if the home situation is not a cheerful one.

We can prevent some accidents by improving attitudes of the worker. We can promote recovery to a state of good mental health by proper handling of the accident. The goal is rehabilitation of the person at the best possible level, with wholesome acceptance of real handicaps but without exploitation of disabilities as a method of adjustment.

The total adjustment of a person in industry affects his productivity. Now that output means so much to our nation, we must see that all that is humanly possible is accomplished. Accidents, illness, and avoidable absenteeism—so much of which is determined by emotional factors—cannot be neglected. They must be handled by getting at the root of the problem. Basically the worker's total personality is involved. We must understand his needs for security, for a sense of adequacy, for a sense of belonging to the group, and his desire for self-expression. Personality difficulties are signs that these are not being

satisfied. By understanding the worker as a total personality we can help him attain and maintain better health. A successful program seeking to promote the health, safety, and efficiency of industrial workers recognizes and uses the principles of mental hygiene, which has as its goal the adjustment of the total person so he can live happily and work effectively.

Presented before the N.O.P.H.N. Industrial Nursing Section Luncheon, Biennial Convention, Chicago, Illinois, May 18, 1942.

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# We Offer Nursing Service to Industry

By LEAH M. BLAISDELL, R.N.

**S**ERVICE TO industries has been offered by the Henry Street Visiting Nurse Service in New York City since early in 1941. Many people have asked our reason for starting this venture. First of all, we realized that a need existed which we seemed to be prepared to meet. To us it seemed urgent that all workers in defense plants be kept at their jobs. Even if they worked in small plants, some essential machine might be laid up and the whole line slowed down while the worker was ill. Most of these small plants could not afford a full-time nursing service and nurses could not afford to do part-time work. Although health programs had been advised by governmental agencies, we believed that many small industries hesitated to inaugurate such a program because they did not know how to get ready for, find, or use such personnel. We were convinced we could help them and smooth out one more complication of increased production until such time as our health department was able to take this leadership.

Then, too, we believed nurses trained for public health nursing had a contribution to make in health instruction of industrial workers. We wanted to see whether that were true, and if so, perhaps to use our service for training nurses for industry.

Finally, we were able to meet this need because of the decreased demand for care of the sick in the home, due to scientific advances such as the use of chemotherapy in pneumonia, and to other reasons such as increased hospitalization. New sources of income were being sought by our agency because of these reasons as well as changes in welfare insurance laws

which decreased our earnings from that source.

As a first step, we consulted the commissioner of health and the director of the bureau of nursing in the New York City Department of Health to see if they considered there was a real need for our assistance in this type of nursing service in our community. They encouraged us to undertake the service.

A list of small firms which had received defense orders was compiled, and a letter and pamphlet explaining our service were sent to about 300. Many firms acknowledged the letter, and several asked for an interview. As a result, we have served ten plants in all, five on a permanent basis and five on a short-time or relief basis.\* We believe this number could have been increased more rapidly if we had assigned a full-time worker to the selling job in the beginning. The slower growing experience has, however, been a valuable one.

## WHAT DO WE OFFER THE PLANT?

In selling service we offer three things:

1. Service of a well-qualified public health nurse. We will send two or three nurses to be interviewed if the management desires, for though they all want a nurse with a moderate degree of justified self-assurance, there is a variation in other qualities of personality desired. Trim appearance is especially important. Above all, it is essential to select a nurse who expects to remain for a reasonable period of time—at least two years—because change is very upsetting. The nurse is covered by our compensation and sickness insurance and enjoys all the personnel privileges of our staff.

2. Supervision of the nurse and relief if she is absent.

\*Three more have been added since the time this paper was written.

3. Consultation on health problems in the plant based on statistical analysis of accidents and illness.

We started out to sell only part-time service, but three plants developed full-time service as soon as they saw the value of the nurse. Part-time service is sold at appointment service rates—\$2 for the first hour and 75 cents for each additional half hour. A reduction in rate is made for four or more hours. Full-time service is furnished at present for the salary of the nurse plus \$10 a month for supervision and relief.

We have found it wise in selling to deal directly with management but to be sure that the person to whom the nurse will be immediately responsible is present at all discussions. We are very flexible about hours and salary in the beginning, writing an informal co-operative agreement which describes a temporary trial period of four to six months with provision for review at the end of that time. Included in the agreement is provision by the industry of the nurse's station and equipment and of a medical consultant who will furnish standing orders and advise in matters other than first aid. This is frequently a physician in the locality who does the major part of the company's compensation work. However, sometimes the company, which is constantly encouraged to think in terms of a future part-time medical service including pre-employment and annual physical examinations, desires to select a physician who will be especially interested in that part of the program. The nurse on the job has many opportunities to point out the financial advantage of such service. An early joint conference of the physician, nurse, and employer is wise, for the nurse finds herself between an employer who desires to cut compensation costs quickly and a physician who is eager for a high type of medical service. These two points of view must be reconciled.

Equipment for the industrial nurse is

simple. An equipped cot, screen, desk and chair, large file, work table, stool, medicine cabinet, scales, sterilizer, and running water are about all that is necessary except the dressings and medications listed in the standing orders, and smaller equipment such as thermometer, forceps, and basins. Purchase of supplies through our supply department has saved the plant trouble in some instances. A nurse's bag equipped with first-aid materials for meeting emergencies in various parts of the plant is a help. A directory of social agencies is another essential tool. Employers have frequently wanted the nurse to wear a white uniform and cap. We have arranged for our standard agency uniform to be made up in white for industrial nurses if the firm is quite eager for it.

#### TWOFOLD JOB OF NURSE

The nurse's work falls into two parts (1) prevention and care of industrial hazards (2) health instruction.

The health education aspects are easy for a good public health nurse. If pre-employment examinations are given in the plant and the nurse starts from that basis, she is overjoyed with what she can see to do and can accomplish. That is especially true if she can tie in to her work the home visiting of a field nurse to give help with employees frequently absent because of illness or puzzling family problems. Accomplishments are so great that our industrial nurses urge us not to be too insistent upon full remuneration for this work at first. Why not let some of our free service be given in this way, they say, when family health work for employees is equally as effective as much of our regular home visiting—if not more so.

Every aspect of health work, from nutrition to family relationships, comes to the industrial nurse for attention and only her own professional limitations stand in her way. She is on familiar ground in utilizing her skills of approach,

listening, analyzing, getting the employee to analyze and plan, sharing scientific information in understandable terms with individuals or groups, utilizing community resources, recording, and summarizing.

Skill previously developed in thoughtful summarizing is particularly valuable. Major catastrophes in industry are infrequent and the minor happenings are insignificant except when they are summarized. Eighty-six visits of one young woman to the nurse's office in a year made one nurse persuade the employee to have that often-suggested medical examination. She did. The discovery of tuberculosis and immediate hospitalization with pneumothorax were very gratifying to both the nurse and employer, who is now favorably considering annual x-rays for all employees. As soon as the nurse grasps the fact that this part of industrial nursing is the same as other public health nursing, she is happy and successful in it. That means a great deal when you realize that illness of nonoccupational origin causes 15 times as much lost time as that caused by both accidents and occupational diseases!\*

The field of industrial hazards is less familiar. Although the nurse has taken courses in industrial hygiene, the variety of situations in different plants is so great that she often loses sight of the simple and practical fundamentals. Apprehension rather than comprehension of the legal aspects seems to be the result of her classroom discussion of workmen's compensation, plant hygiene, and labor problems. Field work in industry in addition to class instruction is needed to break this down.

We wish we lived in a state with an industrial hygiene service in the department of health, from which medical and industrial engineering consultation could

be secured. But since we do not have it, we have tried other plans. The New York State Department of Labor has made available some assistance. The insurance carriers of the individual firms have been very helpful. Some of these insurance companies have nursing consultants. Nearly every company has safety men who know that part of the program intimately and are very willing to work with the nurse in this field. They realize that she will be in the plant every day and can be tremendously helpful in carrying out recommendations they may have been making for years. They also realize that if the worker is well fed and rested and adjusted, much of the personal element in accident causation will be eliminated. The safety man is glad to go through the plant with the nurse and point out its specific hazards and ways of correcting them. He is pleased when she makes a careful record and summary of all accidents by cause and type in each department, and will suggest ways of using this information in correction of hazards.

One of the first conferences in the plant which we endeavor to bring about is a meeting of foremen called by the employer, at which the nurse is introduced and gives a little idea of what she hopes to accomplish. She asks for their suggestions and help. If the safety engineer and consulting physician can be present, that is even better. Frequently this group works out a plan for a safety committee. In any case, periodic meetings in which illness and accident findings are reported and new plans are worked out *with*—rather than *for*—employees are essential to best results.

Record forms and procedures which were developed for the first plant served have been applicable with slight changes to all plants. (The regular case record forms of the agency could be used if one wished.) Forms have been prepared for individual employee's records, for analysis of accidents, and for analysis of all

\*Neal, Paul A. "Industrial Health and the National Defense." *Industrial Medicine*, December 1940, p. 629.

absenteeism. Using these reports as a guide for defining the illness and accident problems in each plant, we hope and believe we can be sufficiently resourceful to find ways to promote better practices in the plants and show for the company financial saving and increased production. Over a period of time we expect these data to help us a great deal also in selling service to other firms.

#### SUPERVISION OF PLANT NURSES

In supervision of this service, care must be taken to strengthen the confidence of the management in the nurse. Since the supervisor has had the first contacts with the plant during the initial period, some skill is required to transfer confidence to the nurse. Only seasoned, capable nurses are assigned and then much leeway is given them in the arrangement of the details of the program directly with management. We welcome this opportunity for our older nurses to develop greater independence. Visits to the plant are made frequently at first, then about once a month or so. At this time the nurse reviews progress, and plans for next steps to make sure they conform to good public health nursing principles. Frequently the plant director comes in for part of this meeting, or the supervisor attends a plant meeting, at which time she endeavors to strengthen the relationship of the nurse to the plant. Free criticism by the management of the nurse's suggested plans will help to keep them practical and useful. The nurse is encouraged to use the telephone

freely to discuss puzzling nursing situations with the supervisor as they arise. This helps her feel close to the nursing organization and tied in with its principles of work. Such a relationship seems to be needed for less well-seasoned nurses especially; otherwise they have a tendency to divorce their work from community planning and to feel that service is a personal or plant matter entirely. Even the nurses themselves have been surprised at occasional lapses such as considering pregnancy in that light, forgetting mothers' clubs, home nursing care, and other community resources that employees might use.

Access to industrial hygiene literature is made easy. All the consultants of the agency help to supply teaching material for plant use. The nurse is encouraged to attend industrial nurses' club meetings and conventions, as well as safety meetings. Dinner conferences for an exchange of ideas of all our nurses assigned to industry are valuable. Although we had them infrequently at first, they are now arranged monthly. Topics and guests are suggested by the nurses themselves.

In this new experiment, we confess to making many mistakes. It is encouraging that we still thrive! We hope that a pooling of experience may eventually yield further guiding principles on nursing service in industry.

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Presented before the N.O.P.H.N. Group Conference on Industrial Nursing, Biennial Convention, Chicago, Illinois, May 17, 1942.

**I**NFORMATION at our fingertips when we need it! The N.I.B.'s new red-covered booklet "Professional Nursing and Auxiliary Services" gives in concise form for ready use the facts that we need every day in recruitment and community planning for nursing. Opportunities in nursing are summarized in a chart giving types of positions, with salaries. Preparation for nursing is outlined, including prerequisites, length of courses, and probable costs. Types of auxiliary nursing service—paid and volunteer—are listed, with the preparation necessary. Copies may be secured at 25 cents each from the Nursing Information Bureau, 1790 Broadway, New York.





Roberta T. was part-time nurse in a plant of 50 to 150 workers in a small New England town.

## NURSE IN A SMALL PLANT

Two thirds of all industrial workers are employed in small plants, comprising 90 percent of *all* plants.

Sick and injured industrial workers lose over 30,000,000 work days every month.

Nonoccupational illness accounts for 15 times as many days' absence from work as do injuries and illnesses caused by the job.

In 1941, accident frequency was 36 percent higher in small plants than in large plants.

Less than two percent of workers in small plants have either part-time or full-time nursing service.

These and many other familiar facts and figures about industry and its health problems constantly remind the public health nurse of her special opportunity to help in the war effort by keeping the war worker well and on the job.

Roberta T. is a young nurse who seized an opportunity to show the value of nursing service in industry. In her plant



The rest of the time she worked on an assembly line—which was an example of bad housekeeping and poor lighting that reduce efficiency on the job.



After two months her good work persuaded the management to employ her full time. She observes sickness and accidents and reports to the doctor.



Cutting oils were a suspected factor in the skin eruption of this lad. Examination showed he should be treated for acne instead of oil dermatitis.

there were no health program, no first aid facilities, no attention to safety measures. A doctor was called in only in case of serious accident. Working on an assembly line half a day, and for a trial period performing an industrial nurse's duties the other half, Roberta demonstrated how a nurse could learn something about machinery and technical processes in the plant, observe sickness and accidents, and in co-operation with the doctor, plan ways of reducing the misery and loss of time they caused. Most important, she was able to build a program for better all-round health and morale in her fellow workers. In recognition of her successful work the management appointed her to a full-time nursing position.

Photographs by courtesy of the U. S. Public Health Service.



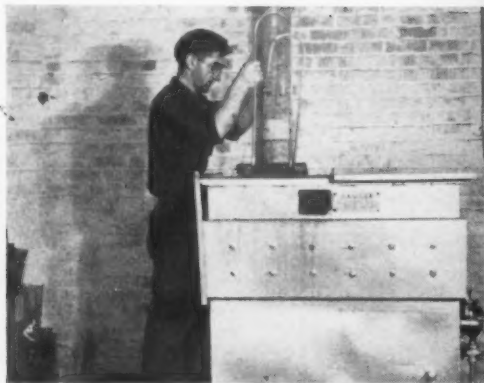
The nurse reports to the doctor cases for study to determine whether they are to be referred to the insurance medical service



John N. used to clean metal parts in a solvent which sometimes gave off poisonous fumes. One day he became ill and fainted. Doctor and nurse decided John would be better off at a job away from the solvent and he was transferred



Tom R., a press machine operator, had had many accidents of left hand. Observation of his work revealed his left vision defect as probable cause



Tom was transferred to a metal-cleaning job which offered no hazard to his left hand. Since then his record has been accident-clear

# Problems in Tax-Supported Medical Care

By GERTRUDE STURGES, M.D.

THE FIRST undertaking of the Committee on Medical Care of the American Public Welfare Association after its appointment in 1937 was a study, by questionnaire and field observation, of state and local organization for the administration of tax-supported medical care. The findings were reported and discussed in a number of publications.<sup>1</sup>

Division and overlapping of governmental authority for the same or similar functions were found in practically all jurisdictions. At least two, and usually many more, governmental agencies are responsible for the administration of parts of the medical program. Two examples will illustrate this fact:

In one eastern state, 12 independent state agencies are concerned with the administration of fractions of the public program. Five of these agencies make payments to nongovernmental hospitals—each at a different rate!

In one town in New England, 11 public bodies, 1 federal, 6 state, 1 county, and 3 local, are all struggling (sometimes with each other) to provide public medical care to a population of some seven thousand.

A recent report by the United States Public Health Service<sup>2</sup> gives the distribution of both public health and public medical services in the structure of state government. The following quotations indicate the nature of the findings:

When one reviews the many interesting findings regarding the total state effort to promote and conserve human health, wide dispersion of functions among multiple state agencies is found to be the most striking.

Realization that within a single state as many as 18 separate agencies contribute something to the health activities covered is somewhat startling. In no jurisdiction are less than 6

agencies involved, and the median number of departments, boards, and commissions concerned with programs having public health significance is 11 per state.

Division of authority is sometimes functional—as, for instance, between preventive and curative services, or between the administration of hospitals and of physicians' service in the home. Responsibility is sometimes divided according to medical category, different agencies being responsible for different diseases or conditions; for example, tuberculosis, mental disease, or crippled children. Frequently different agencies are responsible for the medical care of various economic groups or other groups, such as employable and unemployable persons, or general relief clients and the several social security categories. There are various permutations and combinations of the above types of distribution of authority.

May we assume that because such a welter of agencies is responsible, adequate service is provided? Emphatically, no! The result is frequently a tangled confusion in which many of the essentials of good medical care, such as the following, are entirely lost sight of:<sup>3</sup>

## *Efficiency and economy*

How can service be efficient and economical with several agencies doing the same or similar jobs, each with its own administrative staff, each with its own policies, and each—more frequently than would seem possible—more or less unfamiliar with the others' programs?

## *Prompt service*

The patient frequently waits for necessary care while several agencies decide whose job it is.

*Complete service*

Although several departments may all be responsible for the same type of service, as for example, hospitalization, there is frequently no agency responsible and no service of other essential types, such as physicians' care or bedside nursing service in the home.

*Continuity of the patient's care*

Division of authority impedes—in fact almost precludes—the possibility of continuous medical supervision of the patient through the stages of his treatment at home and in and out of hospital wards and outpatient departments.

The recent tendency to meet each new problem by setting up a new category of service has added to the already thoroughly tangled skein of administrative authority.

**PROBLEMS IN BEDSIDE CARE**

In public medical programs, what are the special problems connected with bedside nursing in the home? Probably the most important is that such service is entirely lacking in some communities. This is illustrated by a somewhat amusing case history which was told the writer in a southern county that had no organized home nursing service.

The landlady who cares for an old gentleman receiving old-age assistance telephoned the welfare worker and asked her to come immediately. When the worker inquired the reason for the urgent visit, she was told that the old man, who is paralyzed, hadn't had a bowel movement for several days, and she thought he needed an "inigma." The worker explained that she had no experience in giving enemas, and suggested calling in a neighbor. Several weeks later the welfare office did not know whether success had been achieved.

In general, the public agencies responsible for medical care depend, for home nursing service, upon nonofficial visiting nurse associations. These have not been organized throughout the entire country. They are especially lacking in rural areas and in the South. The service of nurses

attached to health departments is generally confined to strictly preventive activity and frequently does not include general bedside care in the home. However, in some localities health department nurses provide delivery and postpartum care, under the provisions of the Social Security Act, and to an increasing extent, they give bedside care on a demonstration basis, making one or two visits to the home and teaching some member of the family how to carry on care from that point. But only a few give full nursing service to the sick. The fact that health departments have resisted the acceptance of responsibility for general bedside care, may be the reason why the welfare departments in some localities are developing their own home nursing service to meet a serious unmet need.

This leads to the discussion of another important problem, namely, duplicating and unco-ordinated nursing services. Each of the numerous official agencies which share the responsibility for providing health and medical service in a given locality may employ nurses for some special service; for example, in connection with infant welfare, maternity, tuberculosis, venereal disease, school health, or crippled children's programs. In addition, there may be one or more nonofficial agencies which provide home nursing of some sort, either general bedside care or special service. So we are liable to find in the field of nursing service in the home a tangled confusion of divided and overlapping responsibility similar to the administrative chaos at the top. It is possible in certain communities for several nurses actually to meet in one home. It is also possible, even in communities with a multiplicity of agencies, to find gaps in nursing service, with some essential type of care entirely lacking.

A third problem is that although public agencies depend largely upon non-official visiting nurse associations for nursing care of the needy sick, in many

instances the public agency does not pay for service—not even for care given to persons who are receiving public assistance. Under the Federal Emergency Relief Administration, many relief agencies entered into agreements with nonofficial nursing agencies for payment at agreed per-visit rates for authorized service to relief clients. Some of these agreements have since been given up by the welfare agency which succeeded the emergency relief administration. Some localities have never paid the nonofficial agencies for their service to the indigent. There are those who hold that such service should be provided by governmental rather than voluntary agencies: that all nursing service in the home—preventive, educational, and bedside—should be centralized under the department of health. Be that as it may, in localities where a governmental agency does not provide bedside care and the nonofficial public health nursing agency gives service to the welfare client, the question of payment for such service, just as for that of voluntary hospitals, is in order.

Another typical difficulty is that even in the localities with sufficient care available, bedside nursing service is not always called upon to the most useful extent; for example, the relative proportions of physicians' to nurses' home visits reported is as low as ten to one. Authorization for nursing service is usually the prerogative of the physician on the case and the impression is reported that "the poorer the physician, the less liable he is to call a nurse"; that the less able practitioners "are afraid to have a nurse on the case." Other factors said to impede the full use of nursing service are the "bother" of writing the authorization form, and where funds are low, the desire to conserve them for payment to the medical profession.

What can and should be done to better our organization for the administration of public medical service?

#### SUGGESTIONS FOR CO-ORDINATION

The Committee on Medical Care of the American Public Welfare Association has made specific proposals for the unification or co-ordination of responsibility, briefly:<sup>4</sup>

1. The development of a co-operative relationship whereby the welfare or other department charged by law with providing medical care obtains service or technical supervision through the department of health and pays for such service accordingly. [This suggestion and the following one do not, of course, apply in localities where health departments already administer all public medical service.]

2. The official use of the state or local health officer, by ex-officio appointment or otherwise, in an advisory capacity to the welfare or other department carrying the major responsibility for tax-supported medical care.

3. The organization of representatives of the governmental agencies concerned with medical care and welfare into an interdepartmental committee, for joint planning of official programs and conference with nongovernmental agencies and the medical professions. . . .

4. The utilization of a medical officer on the staff of the welfare department or other governmental agency primarily concerned with the administration of medical care, in a liaison capacity with other governmental departments as well as with the nongovernmental agencies and the medical and allied professions concerned.

The American Public Welfare Association has urged welfare administrators to co-operate to the fullest extent with the other governmental departments concerned, in planning to avoid duplication and gaps in public medical service; and has published a description of typical co-operative machinery and relationships which have been developed at the federal, state, and local levels.<sup>5</sup> Many of these illustrate the proposals stated above.

Well before Pearl Harbor, Paul V. McNutt, administrator of the Federal Security Agency, stated:<sup>6</sup>

It is my firm belief that we must plan a long-range program for the health of all the American people. Not a program for one favored disease or one favored group of the population, but a comprehensive co-ordinated



effort for the maximum possible control of illness of all types and for the benefit of people of all ages and all incomes.

One important means of reaching this objective is the unification and co-ordination of health agencies at the federal, state, and local levels.

Now that we are in the midst of a national emergency, we may be forced by necessity, as the British have been, really to pool our resources.

#### HOW PROBLEMS ARE BEING MET

Although it may be difficult, during the present acute shortage of nurses, to increase the number of those available for bedside care of the needy sick in their homes, at least progress can be made in co-ordinating existing service to eliminate wasteful duplication. The development of co-operation in the administrative machinery at the top will further this end; but the nursing agencies can themselves initiate and organize co-operative arrangements to eliminate confusion and duplication. The Committee on Health Programs at the Conference of State and Territorial Health Officers has recently made an important recommendation bearing on this problem:<sup>7</sup>

The Committee has noted the existing shortage of qualified nurses and a probable inadequacy of hospital facilities. It believes that the deficiencies in both categories are likely to increase rather than diminish. It follows, therefore, that existing resources should be utilized in the most efficient manner possible. Many hospital beds could be made available for cases needing this type of care, if a sufficiency of home nursing care were provided.

Home nursing care on a visiting nursing basis should not only greatly enhance the value of the individual nurse to the community but distribute nursing service more nearly according to the patients' needs. In the opinion of the committee, bedside nursing care is a proper function of a generalized public health nursing service. It should not replace the services usually rendered by public health nurses, but should supplement them. Where a visiting bedside nursing service does not exist, every effort should be made to establish such a service, preferably within an existing official public health agency. Furthermore, the pro-

grams of all agencies—public and private—employing public health nurses should be co-ordinated in order to provide against duplications in nursing service and to utilize most effectively every public health nurse employed. The tendency should be toward consolidation rather than toward the establishment of new organizations to meet recognized needs—toward a pooling of resources rather than a wasteful competition for community support.

The National Organization for Public Health Nursing has furnished the writer with a list of 19 localities in which co-operative relationships have been effected.

A study is now under way by the Committee on Nursing Administration of the National Organization for Public Health Nursing, of certain communities in the United States which have no organized care of the sick in their homes. This study has been made possible by a limited grant from the Metropolitan Life Insurance Company, and has the support of the nursing services of the U. S. Children's Bureau, U. S. Public Health Service, and American Red Cross.

Some ways in which the needs for such service are being met are through: (1) the combining of agencies (2) the development of service for nursing care of the sick in health departments (3) the development of new nonofficial agencies in some places (4) an expansion of services of existing visiting nurse associations to include areas not heretofore served. In some cases, visiting nurse services are being developed under the Red Cross, especially in rural areas. In addition, it is hoped that nursing councils for war service which are now functioning in the emergency, will later be developed into community nursing councils through which plans for the distribution of bedside service in the home can be worked out.

In a goodly number of communities public welfare agencies have worked out agreements with visiting nursing associations for payment on a per-visit basis for service rendered to welfare clients. New

York City was one of the first to do so in 1931, when the original program for medical relief was developed—the principles of which were carried over into the medical care program of the Federal Emergency Relief Administration. After a battle royal, in which the writer freely participated, the advisory committee of social workers were finally convinced that it was necessary and equitable to use relief funds to pay for home nursing care as well as for food and lodging.

In some instances, agreements between public welfare authorities and public health nursing agencies have been developed on a statewide basis. Two examples are cited here:

The Pennsylvania State Department of Public Assistance has an agreement whereby nursing agencies are paid at the rate of 95 cents a visit to welfare clients. One unique feature of the Pennsylvania plan is that the patient or a member of his family is allowed to call in the nurse without waiting for the physician to do so.

The Massachusetts Department of Public Welfare has recently issued a statement of policies for agreements between visiting nurse associations and welfare boards. The local welfare boards may be reimbursed for payments to nursing associations up to the rate of 75 cents a visit, according to the Massachusetts plan.

There still remain, however, many localities where nonofficial nursing agencies are not compensated for home nursing care to welfare clients and other persons who are public responsibilities. The days when voluntary contributions were sufficient to provide such public service are gone; and government must

assume its responsibility either through payment to nonofficial agencies for service rendered or through development of its own service.

A number of devices have been developed to increase the use of bedside nursing:

As noted above, in the program operated by the Pennsylvania Department of Public Assistance a member of the family is allowed to call in a nurse without waiting for the physician's authorization, although the nurse does not make more than one visit without the physician's order.

The New York City Department of Welfare has adopted the policy of routinely authorizing home nursing service for patients with measles, scarlet fever, and pneumonia, and also for maternity patients to be delivered at home.

The New Haven Visiting Nurse Association secures daily a list of the patients for whom city physicians have been called, and then telephones each physician concerning each patient to ask whether he wants a nurse sent in. This practice takes some time but has been working well for several years.

#### CONCLUSION

An attempt has been made to state the problems of organization for the administration of public medical service and the special problems of home nursing care in public programs; and to suggest some ways and means for their solution.

The expenditures of federal, state, and local government for medical care are increasing in this country. Unless real progress is made in co-ordinating existing governmental machinery for medical care administration, however, additional expenditures, no matter how great, may not result in an adequate well-rounded program for medical care.

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## A Dentist in a Trailer

By FLORA H. BOOTH, R.N.

A co-operative program of the health department, rural schools, and dental society for care of children's teeth

A RURAL dental health service for the children in the schools has been developed in Summit County, Ohio, through the co-operative efforts of several agencies concerned with the problem of the children's teeth.

While having lunch one day, our health commissioner happened to sit beside a young dentist who had grown up in the county. They discussed the need for dental care of school children. The health commissioner urged the young dentist to commence his practice in the rural section of the county because the need there was so great, and the facilities were so few. This seemed to strike a responsive chord in the young practitioner's mind and later he came to talk over with the health commissioner what might be done to provide care for the children in the rural schools. Thus the seed was sown and it began to grow and finally to bear fruit.

### DENTAL SOCIETY CO-OPERATES

A plan for having a trailer equipped to give remedial dental care to school children whose parents could not pay

for care was made with the help of the young dentist, and presented by the Summit County Health Department to the dental society. The society appointed a committee to study the entire problem. The plan for the trailer was approved and the dental society agreed to assist the Health Department in working out a dental program for the county schools.

The laws of the State of Ohio place the responsibility for dental care of indigent children upon the schools. The co-operation of the county school superintendent and the township school district superintendents and principals was sought in securing the help of their respective school boards to finance this program. Thirteen of the school districts responded. The dental program was set up on a co-operative basis, with the school boards furnishing half of the funds necessary and the Health Department the other half.

A trailer was secured and equipped as a dental office. Forms were designed for recording the findings of the dental examinations and sending notices to the parents. On the form letter to parents a place was provided where they could state whether they were able to provide necessary dental care or whether they

needed assistance for this care. Then the program was launched. A dental inspection was made of all elementary school children in the 13 school districts, and a record kept of the condition of the teeth of each child. Reports were sent on the form letter to the parents of children needing care.

Soon the letters began to come back. The nurses made a sincere effort to secure a one hundred percent response. The result was gratifying. More than two thirds of the children brought letters agreeing to have their teeth taken care of. The children, the parents, the teachers, the principals, and the superintendents of the schools were enthusiastic about the program.

#### ELIGIBILITY FOR CARE

In order to determine the eligibility of those who requested dental care by the school dentist, the assistance of the county relief agency was secured. The township trustees and the superintendents and principals of the schools gave information concerning the financial status of these families. Many of them were already known to the nurses. Final decision rested with the Health Department, which used the criteria set up by the relief agencies. The committee of the dental society permitted flexibility in regard to those who were borderline cases—that is, medically needy though not indigent.

The dentist made rounds of the schools to give remedial care to children approved for such care. By moving from place to place, spending a few days at a time in each school, he visited each school at least three to four times during the school year.

During the first year, 1940-1941, there were 4199 dental examinations made. About 80 percent of these children were found to have dental defects. An average number of 4.4 cavities per child was found, over half of which were in the permanent teeth. Thirty-nine percent

of the children had never visited a dentist before. The dental work done was as follows:

Extractions	
Permanent teeth	63
Deciduous teeth	79
Fillings	
Permanent teeth	1996
Deciduous teeth	25
Prophylactic treatments	318

Remedial care was given to 420 children, of whom 168 made revisits to the trailer for further care. Since the care was necessarily limited, stress was placed upon the permanent teeth. Upon the advice of the dental advisory committee and the chief of the dental division of the Ohio State Department of Health, special attention was given to the six-year molars.

Statements in regard to dental care given by private dentists also began to come in. After two months a progress report was made to the committee of the dental society. They were pleased with the results of the program, both the care given by private dentists and the work of the school dentist. Later several dentists were chosen by the society to inspect the teeth of all of the 3000 children in the elementary schools of the city of Cuyahoga Falls, which is within the jurisdiction of the Summit County Health Department.

The program was so successful during its first year of operation that the Health Department was requested to continue the service during 1941-1942. Two additional districts asked to join in the program. During the past school year, inspections were made mainly on first-grade pupils and high-school students. Those who had been given remedial care during the first year had a recheck and wherever the financial status remained unchanged, necessary additional care was given by the school dentist. In all, 419 children were given dental care, and 304 children made revisits for further care.

There were many more revisits this year than last due to the fact that the older children were given care and many more cavities were found in this age group.

A survey showed that 1582 children had received dental care from private dentists since the beginning of our dental program.

Due to complications which arose in administration of the law providing for dental care of needy children, a bill was drawn up by the health commissioner to amend this section of the general code of Ohio and it was adopted by the state legislature. As a result the plan for financing of a co-operative dental program by the county schools and the Health Department has been simplified.

#### PREVENTION NOT NEGLECTED

The dental program has been carried on as part of a generalized public health program. During the dentist's visit to each school, an educational program in dental hygiene was carried on because the superintendents believed this was a time when interest was highest. The program included talks by the nurse and health commissioner, and the use of movie films. Increased interest in the whole health education program has resulted, including the development of a timely program on nutrition and health. In the dental program next year, more time and effort will be given to health education, along with the necessary remedial care.

### NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

#### PLACEMENTS

- \*Elizabeth McIntosh, director, Visiting Nurse Association, Muncie, Ind.
- \*Sara B. Sprouse, supervisor, Peoria Health Department, Peoria, Ill.
- \*Kharis B. Mayers, assistant supervisor, Baltimore County Health Department, Towson, Md.
- Ralph Althouse, industrial nurse, Illinois State Department Public Works and Buildings, Springfield, Ill.
- Mrs. Edwina Rubinstein, relief industrial nurse, Greenebaum Tanning Company, Chicago, Ill.
- \*Elaine Goben, county public health nurse, Lamar Prowers County, Colorado State Department of Health, Denver, Colo.
- \*Hallie McIntosh, school nurse, Stephenson County, Freeport, Ill.

- Frances A. Sweeney, camp nurse, Camp of United Charities, Algonquin, Ill.
- Ethel May Dvorak, camp nurse, Camp Oak Openings, Saugatuck, Mich.
- Willette Dooley, staff nurse, Visiting Nurse Association, Detroit, Mich.
- Mrs. Cora Amelia O'Day, orthopedic staff nurse, Visiting Nurse Association of Oshkosh, Oshkosh, Wis.

#### ASSISTED PLACEMENTS

- \*Mrs. Marion L. Juergens, assistant to director, special consultant on volunteer nurse's aide, American Red Cross, North Atlantic Area, New York, N.Y.
- \*Alice M. Fay, director of public health nursing course, Incarnate Word College, San Antonio, Texas
- \*Lillian E. Upham, nursing consultant, American Red Cross, St. Louis, Mo.
- \*Mrs. Pauline W. Mathewson, supervisor, Instructive Visiting Nurse and Tuberculosis Association, Newport News, Va.
- \*Katherine M. Schweikart, instructor public health nursing and assistant director, St. Louis City Hospital, School of Nursing, St. Louis, Mo.
- Mrs. Lillian A. N. Monks, staff nurse, Visiting Nurses of San Diego, San Diego, Calif.

\*The N.O.P.H.N. files show that this nurse is a 1942 member.



# Born---A Daughter

By JANET F. WALKER, R.N.

**This family case story shows skilled maternity nursing care which is adapted in specific detail to the difficult problems revealed in the family**

Born, to Mr. and Mrs. Harry Schmidt, a daughter, May 5.

A NEWSPAPER notice, terse and simple, announces an accustomed event. But behind many a birth notice lies a story of struggle and anxiety that probably had its beginning long before. This was true in the case of Mr. and Mrs. Schmidt.

The part the visiting nurse played in this story, and her many-sided knowledge of its whole began seven months before the newspaper item was published, when an insurance agent referred Mrs. Schmidt to the visiting nurse association.

The patient turned out to be a young married woman of twenty-seven years in the second month of her first pregnancy. She showed mingled emotions of joy and dismay over her condition. Her joy was occasioned by this common event that in happening to them had become unusual. Her regret came from fear that she would be unable to care for the baby after its arrival, for her right arm had been amputated at the shoulder when she was eight years old. She had been hit by a train while playing in the "flats." In spite of her handicap, this Lithuanian born, American bred girl had finished high school, studied two years at business college, and held a position for three years as a private secretary.

She had become adept at concealing the empty socket with the proper clothes, and a stranger, unless particularly observing, might be with her several mo-

ments before detecting it. But these years had not made her insensitive to her handicap, and so she had joined the handicap club at the Young Women's Christian Association. There she met Harry Schmidt, an American born, German boy who walked with a slight limp, the result of a childhood accident that left him with a right leg two inches shorter than the left. He had made such compensation for this difference that the limp was barely noticeable. His membership in the handicap club gave evidence of his own consciousness of it.

Their friendship, born of a common interest, developed into love. Fearing parental objection from both families, they eloped to New York after a brief courtship and were married by a justice of the peace—this stocky, dark-haired Greek Catholic girl and the slim, blond Lutheran boy. But neither was happy at the means used to attain their end.

Now after a year of comparative happiness, they were faced with a big responsibility. The economic aspect was of major importance at the outset. Of even more importance to the mother—it later developed as pregnancy advanced—was the secret horror that she had marked her unborn child with her own deformity. For she brooded over many unhappy phases of her life, of which the nurse at first had no knowledge.

## THE FAMILY BUDGET

Even without this new expense, the family income was barely adequate. Mr. Schmidt was employed as a paint

sprayer, working by the hour and earning from \$80 to \$100 a month. Occasionally in a good month he could earn \$130, but offsetting this always was the possibility of a layoff during the slack summer months. Infrequently, he earned small sums doing sign painting in his free time. Their rent was \$14 a month, and current expenses of gas, light, coal, laundry, food, milk, and insurance came to \$38. Furniture installment payments, which could not be completed for another 15 months, were \$15 a month. There were two department store bills totalling \$40, on which they were trying to pay \$5 a month each. Against an average income of \$90 a month were the fixed expenses of \$72. This did not include clothes, dental and medical care, amusements, savings, and incidentals. Added now was a doctor bill of \$50 and a hospital bill of \$45, the latter to be paid in full before delivery.

The neighborhood in which the Schmidts lived was poor. Located near the downtown area on a main thoroughfare, the house in which they occupied a second-floor apartment was flanked by massive factories that filled the air with smoke. Yet they had shopped well for this home. The house had been built far back from the street in a more prosperous era, when the neighborhood was a good residential section, and it gave better than usual returns for \$14 a month in rent. It still retained the full yard with a smooth, green lawn and a few shrubs, flowers, and trees which flourished despite the smoke.

Their four rooms were light and well ventilated, but because they were directly under the roof, hot in the summer. Heat in winter was secured from a coal stove in the center room. The rooms were simply but attractively furnished. Harry Schmidt had painted the walls and woodwork and cupboards himself, and had laid the bright linoleum of ivory patterned in red and black. The bathroom, though larger than the bed-

room, contained nothing but a modern flush toilet.

In this setting, the nurse met both parents on her first visit. The mother was under the care of a private physician and planned to be delivered in a hospital. She seemed in excellent health except for a rapid pulse that stayed between 90 and 100 throughout pregnancy. Neither she nor her husband had ever had a serious illness except for the accident each had suffered in childhood. During the first three months, the mother had slight nausea in the morning, but rarely vomited. A monthly urinalysis and blood pressure measurement by her doctor indicated normal kidney function. There was no edema except during the last few months, when it appeared in the extremities, chiefly from the pressure of the growing fetus. She rarely had headaches or disturbances in vision. She was, however, constipated, a chronic condition dating back to childhood and necessitating daily cathartics or enemas. With proper diet, moderate exercise, improvements in posture, and the formation of regular bowel habits, this condition was almost completely corrected by the end of the pregnancy. Her breasts were small and well formed with fairly prominent but not large nipples.

#### INFANT CARE DEMONSTRATED EARLY

Because of the mother's handicap, it was evident that special plans were necessary to teach her an adaptation of the procedures in infant care before the arrival of the baby. On the first visit, the nurse suggested that the mother secure a rubber baby doll which could be washed, so that methods of bathing and handling it could be demonstrated and practiced.

A tentative plan for each visit during the antepartum period was outlined but it served only as a flexible guide for the entire period.

Each visit served to cement further

the rapport begun on the first. Succeeding visits also brought to light emotional difficulties and anxieties that the mother had been unable to discuss with others, and which were becoming of paramount importance to her. During the first three visits, which were made around four o'clock in the afternoon, both parents were at home. The father's presence was a definite advantage in that his interest in the coming baby was increased and he became an active participant in all practical plans for its care and showed great delight in making equipment to be used. His presence was a disadvantage in that the mother said little about her own health when he was there. She did, however, make occasional, veiled references to being "very nervous."

#### INTERESTS VARY WITH MOODS

The fourth visit was made early in the day. Although Mrs. Schmidt was alone, she did not refer to the things that were troubling her until the nurse was leaving. This proved to be characteristic of her. She was moody and impulsive—volatile and happy at one time and in the depths of despondency at another. She was never sullen but frequently very quiet. This usually indicated, as the nurse came to understand her, that an inner conflict was in progress—whether to tell or not to tell, to explain or to leave alone. As her moods rose and fell, so also did her interest in the plans being made. Quick to become interested, she was just as quick to lose interest. Finally in spite of her reticence about personal and family matters, she began to talk freely with the nurse about them.

Suddenly on that fourth visit as the nurse arose to go she said, "I have so many things I would like to talk about—I can't discuss most of them with anyone else and I find it very hard to talk even with you."

She was tormented with many anxieties, each of a different kind, but all converging in the fears that she might mark

her baby, die in labor, or lose her mind. Because the sexual relationship of marriage was distasteful to her, she was certain that a baby conceived in such a union would not be normal.

In addition, she had horrible, fantastic dreams from which she awakened in panic, unable to orient herself immediately. These dreams were a repetition of similar ones which she had had during her period of employment a few years before.

After business college and before her marriage, May Schmidt had worked for a short time in the office of an organization for the crippled. Following this employment, the association had secured a position for her as secretary in a concern that specialized in the making of artificial limbs. This company was owned by two men. One partner traveled as a salesman. The other directed the work in town. The latter was erratic and unhappy with his wife, drank extensively, and annoyed his secretary with unwanted personal attention and maudlin recitations of his marital unhappiness. She had made several attempts to leave this position, but each time was persuaded by the traveling partner to return. She had found few positions open at that time even for the normal young girl and none for a girl with but one arm. She never informed the association which had referred her to the position of the difficulties encountered there.

#### OLD ANXIETIES INTENSIFIED

Coupled with this dissatisfaction had been the constant contact with cripples for fittings and measurements of their artificial parts. Many of their deformities, like her own, had been acquired. Some were congenital. She had dreamed of these people at night and only gradually forgot them after she left the company to be married.

Yet here they were again, crowding her sleep with their deformities, always with the prominent display of their arms

and legs. Frequently these were outstretched as if crucified on a cross. Sometimes they were twisted or crushed; attached to the body or amputated; in casts, on crutches, or artificial—but always there. And the nightmares always ended in a crescendo of accidents, of crushed machines or trains. They varied in detail but there was no escape from them. They filled her nights. They haunted her days with the horror of the effect they were having on her baby.

As a result of all this, Mrs. Schmidt sometimes had the feeling of being not herself, but instead "another person floating in space." She found it difficult to describe these sensations. But while they occurred only infrequently and lasted from a few moments to an hour, they frightened her terribly and she was afraid she was "losing her mind."

No attempt was made by the nurse to go into these dreams, but the patient was advised to discuss them in detail with her physician, and the nurse also reported them to the doctor.

#### KNOWLEDGE HELPS DISPEL ANXIETY

Hoping to allay these fears, the nurse described the process of the growth of the embryo. She demonstrated with diagrams what happens in the formation of a new life: the union of male and female sex cells, the restoration of the normal number of chromosomes, half from each parent, so that at the moment of conception all of the potential characteristics of the baby are there. She explained why acquired characteristics of the parents are not inherited; that there is no direct connection between the blood and nerve supply of the mother and those of the fetus.

She explained that maternal impressions do not affect the baby. She told the mother, however, that with every pregnancy there is always a possibility of some cells not developing, or of some congenital injury; but that "congenital amputations of otherwise normal mem-

bers are rare, occurring certainly no more often than once in a thousand pregnancies."<sup>1</sup> She emphasized that each prospective mother is faced with this remote possibility equally as much as Mrs. Schmidt. To allay any fears about inherited characteristics, she quoted Dr. J. W. Ballantyne, an authority on this subject, who said that "the most hereditary thing in the world is the normal, not the abnormal."<sup>2</sup>

Gradually, Mrs. Schmidt's fears subsided and she was able to use the knowledge she had acquired to dispel anxieties that came up from time to time. After once dispelling a fear with understanding she did not again return to that original fear but she did develop new ones. There were all too many friends and relatives to frighten her with stories and new worries, such as the dread that with only one arm she would be unable to pull on the straps while in labor and so "force the baby out," and that if she could not do this the labor would kill both her and the baby. To meet this anxiety, diagrams and a discussion of the muscular contractions and the process of labor were used, and these again sufficed to allay her fears.

However, one real cause of her fear of death was not removed. Brought up in the Greek Catholic religion, she had been married by a justice of the peace. Living outside the church of her belief, she greatly feared death. Yet there was no obstacle to remarriage by a priest. Mr. Schmidt was not only willing, but anxious that this be done. A church and parish house of her own faith were but a few doors away. When arrangements for this ceremony were all but completed, she changed her mind, refusing to be remarried while she was large with child. She decided with considerable finality to wait until after the baby was born; then to have the marriage ceremony and the baptism of the baby both performed on the same day. It was therefore postponed till the baby was two months old.

Her physician, who gave her excellent medical care, was informed of her dreams and emotional disturbances. He kept her under close supervision and thought she would improve as pregnancy advanced. And she did improve. So gradually did this come about that she herself was unaware of the change until later. Unless she was too fatigued, which rarely happened, her nightmares did not occur. Her sensations of floating became less and less frequent. She began to look forward with pleasure to the time when she would have her baby. It was not until she was actually in labor that she realized, as she later explained to the nurse "how long it had been since I was afraid of all that might happen, but I wasn't afraid then."

However, even with this improvement that began and continued during her pregnancy, there was sufficient emotional disturbance—including her maladjustment in relation to her husband—to call for early psychiatric assistance. An explanation of the real reason for the referral would have reinforced her fear that she was mentally abnormal. Throughout the discussion of these emotional disturbances the nurse had tried to emphasize the fact that every normal person has fears, which vary only in kind and degree. She had also explained that during pregnancy the endocrine system is under greater strain than usual and that normal emotional reactions are often exaggerated. She had suggested that the best method of reducing these apprehensions was to bring them out into the open and discuss them freely with the doctor and nurse as they arose—not to think of them as something abnormal to be kept hidden in the dark, thus gathering momentum by their repression.

#### REFERRED TO CASE-WORK AGENCY

Some other reason for referral that would not excite the mother was needed. In spite of their limited income the

family seemed to be getting along without financial aid and showed no desire to discuss finances other than casually. But two months before delivery a comment about work in general and Mr. Schmidt's in particular brought a response that showed the mother's anxiety in regard to the financial situation, and she talked about their problems in detail. The possibility of assistance with budgeting from a case-work agency was discussed, together with a general description of the broader functions of that organization. It was decided that Mrs. Schmidt would talk the matter over with her husband. She herself brought it up again on a later visit. But it was not until three weeks before the baby was born that the family voluntarily asked for referral. Although the financial aspect had been emphasized, both seemed to understand that the agency was going to be of even greater service to them than that.

The physician agreed that the parents should be given any help possible. The nurse had a conference with the supervisor of the district branch of the family agency, and a worker with psychiatric training was assigned to the family. Within a week from the day of their decision, the first interview between the worker and the mother had been held and the family was accepted by the agency for service.

#### SUITABLE DOLL MADE

In planning for the care of the baby it seemed wise to teach the mother some of the procedures in infant care during the antepartum period. It was necessary to adapt the procedures to the mother's single arm and to overcome her fears. Moreover she needed actual proof through accomplishment that she could become skillful in handling the baby. On the first visit, as mentioned before, the nurse had suggested a rubber baby doll for use in demonstration and practice. The family had been sure they



could secure such a doll. When several weeks had gone by and they were still unsuccessful in finding one, the family and the nurse decided to make a doll of the same size, proportion, and weight as a newborn baby, using oilcloth and sandbags.

With an anatomy textbook as a guide, the nurse made a paper pattern, 23 inches long. This allowed two inches for seams, and as slack in stuffing. According to a diagram of the total length of the newborn baby,  $\frac{1}{4}$  of the length includes the distance from the top of the head to the center of the neck;  $\frac{1}{4}$  from this to the small part of the waist;  $\frac{1}{4}$  from the waist to the middle of the thigh; and  $\frac{1}{4}$  from the thigh to the sole of the foot.<sup>3</sup> About 5.7 inches was allowed for each fourth.

Other measurements for the pattern were taken from data in the book.

For weight, clean sea sand was secured free of charge from the local fire station and made into several small sandbags.

The making of the doll was planned for three o'clock on Saturday, when Mr. Schmidt would be at home. It was a time-consuming project requiring three hours in all. This included the cutting out and sewing of the oilcloth, the making of individual sandbags to fit each part, and finally the stuffing of the doll. The time required was longer than necessary due to the fact that the mother had an old sewing machine badly in need of repair, and both the thread and the needle broke frequently. The nurse could have made the doll at home in less time but it seemed best to maintain the interest and participation of both parents.

Two patterns were cut from the oilcloth and sewed together on the right side, leaving raw edges all the way around with the exception of two openings for the sandbags, one at the top of the head, the other from the left axilla to the thigh. The six sandbags were made of double thickness of clean cloth,

a round one for the head, a rectangular one for the trunk, and four long, narrow ones for the four extremities. Because sand is heavy, very little in volume was needed for the total weight of seven pounds. After the bags were placed in position through the openings, starting first with the extremities, cotton was packed around them to fill out the parts and give roundness to the body. Finally the openings were closed by sewing the edges together with an overhand stitch. The father later painted features on its face and it was named Allen-Yvonne to take care of both sexes. Because of the individual sandbags, its head flopped like that of a newborn baby and the movement of its arms and legs was also uncertain.

#### CLOTHING ADAPTED TO NEED

A simple but complete layette was purchased by the mother with money given by the paternal grandmother. Each article was planned so that the handling and turning of the baby by the mother would be reduced to a minimum and dressing made as simple as possible. Diapers to be tied, not pinned, were made by the father from a pattern previously made by the nurse. Mrs. Schmidt had no difficulty with bows, knots, or buttons, but was worried about pins. The gowns opened down the front—rather than down the back as is usual—tying at the neck. The shirts also buttoned down the front. The diapers when on the baby resembled little pants tied in front. They could be adjusted by overlapping on the sides and by changing the size of the bows to fit the baby, until the time when it would be ready for training panties.

Several baby showers from friends brought additional gifts and the employers of Mr. Schmidt's sister donated a wicker bassinet and baby scales.

Mrs. Schmidt had shown such a marked fear of giving the baby a tub bath that some other means of bathing

had to be improvised. She was even afraid of the newer "bathinettes" with a slanting canvas back rest extending into the tub, on which to support the baby. A bathing board patterned on the principle of the Kelly pad had been made by the father previously. This was to be used on the kitchen table, which was to be placed at right angles to the kitchen sink. Made of wood,  $3\frac{1}{2}$  feet long and 2 feet wide, the bathing board had a three-inch railing around three sides. The fourth side, which was in contact with the sink, was two inches lower than the opposite side for drainage purposes and lacked this railing. The whole structure was covered with white oilcloth tacked on the under surface. A piece of the oilcloth extended like an apron from the board into the sink. The railings served the functions of forming a trough to facilitate drainage of water and prevent the baby from rolling off. When the board was in use, a small quilted bed pad was placed over the oilcloth within the trough for the baby to lie on.

#### MOTHER PRACTICES PROCEDURES

Since it was late in the day when the doll was completed, the nurse planned to give the demonstration of bathing and dressing on the next visit. When the day came, the mother was in very low spirits, disinterested and noncommunicative, with no evident desire to continue with the plans. This was in marked contrast to her enthusiasm on the previous meeting. She had said to the nurse, "I don't think you need to show me how to bathe a baby. There can't be very much to doing that." She was not unfriendly, however, and she did ask the nurse to take off her hat and coat. Ignoring this mood, the nurse began to prepare the kitchen and bedroom for the bath. She explained as she did so that it wasn't because the bath was difficult, but because several methods could be used that rehearsal was important to select the simplest way. This was necessary in

order to avoid undue exposure of the baby and to save the mother's energy.

Without comment Mrs. Schmidt sat and observed the nurse while she demonstrated the complete procedure—which is outlined below—and explained the reason for each step. The mother watched with increasing interest and asked to return the demonstration immediately. In doing so, she made several excellent suggestions for changes including the use of the two basins and washcloths—one for soapy water and one for rinsing. From then on to the termination of her pregnancy her interest, although fluctuating, was sufficient so that she practiced the complete routine once or twice a week and the dressing, lifting, and turning almost daily.

#### PREPARATION FOR BATH

The plan for the bath was as follows:

1. The clothes were laid out on the mother's bed in advance exactly in position to lay the baby on them, with the shirt sleeves inserted in those of the gown. The bed rather than the bath table was used in order to give the mother plenty of working space and a sense of security for the baby in dressing it.

2. The articles were placed so that the mother could reach them with ease, with the bath tray on the sink board, the two small basins of warm water on the kitchen table at the head of the bathing board, and the bath towel on a chair in front of the table.

3. The usual bath procedure was adapted to the mother's convenience. After the bath the baby was carried in a towel to the bedroom, placed in the center of the clothing, and dressed. No turning was required for this process.

#### TURNING THE BABY

The mother practiced turning the baby, standing with the doll's head at her left.

To turn the baby from its back to the prone position the mother placed her

thumb and forefinger at the two angles of the jaw. The other fingers were placed on the shoulder with her palm over the neck and her wrist and forearm on the chest and abdomen. With a turning or sliding rather than a lifting motion, the baby was turned toward her and over in a prone position, resting flat on her arm until she withdrew it.

In turning the baby from the prone position over onto its back on the bath towel, she turned the baby's face to the right and extended its left arm above the shoulder parallel with the head. With her fingers and palm supporting the head and neck and her thumb under the right axilla, the doll was rolled back on her forearm and onto the towel. This method was chosen after practice as the simplest and most convenient, and the one giving greatest protection to all parts of the baby.

The methods for supporting the baby while nursing, with the mother in both the sitting or lying-down positions, were also planned in advance. For the sitting position a sling was made by the father of double thickness, unbleached muslin triangular in shape, with the tapered ends sewed together making a complete circle that could be slipped over the mother's head. Darts in the body of the sling toward the apex formed a hammock to hold the baby while nursing, so that the mother's hand could be free to support the breast and direct the nipple.

#### GLORIA ARRIVES

The nine-and-a-half-pound baby girl was born in a private hospital after a 30-hour labor.

An episiotomy was done on the mother to facilitate delivery. During the eleven-day stay in the hospital, the mother's breasts secreted so little that her doctor put the baby on a formula. When Mrs. Schmidt returned home, the episiotomy was well healed; her bowels were moving regularly without artificial aid; the

fundus of the uterus was nonpalpable; and the lochia was scant and serous.

Mrs. Schmidt had previously been assured that on her return from the hospital, the nurse would make daily visits until she gained sufficient confidence to bathe the baby alone. Only three such visits were necessary.

On the first postpartum visit the nurse again demonstrated the procedure for the bath, with the active, squirming nine-and-a-half-pound Gloria instead of the seven-pound doll. A twenty-four-hour schedule for both mother and baby was planned and the preparation of the formula was demonstrated to both parents. The father decided that he would prepare the formula until the mother felt stronger, and the next day he returned the demonstration. On the second day the mother with the aid of the nurse bathed the baby. On the third day the mother prepared for and gave the bath completely unaided, while the nurse sat by to give assistance if needed. No assistance was necessary. From previous practice the mother was sure of every movement. She showed no fear and was very skillful in handling the baby with her one arm.

A slight change was made in the original plan. Instead of dressing the baby on the mother's bed, Gloria's clothing was laid out in her bassinet, on which the father had put small rubber-tired wheels. It was then wheeled into the kitchen to the head of the table. After being dried, Gloria was placed directly in her own bed and dressed in the kitchen, then wheeled into the bedroom.

#### MOTHER'S SKILL INCREASES

Because of her skill and the desire that she should not become too dependent on the nurse, the mother was left to manage the baby alone for the next few days. However, on the second day following a friend telephoned the office asking the nurse to call. The message said: "The baby is crying a

great deal. Neither the mother nor the father is getting much rest. Their own doctor is out of town and Mrs. Schmidt is sure the baby is sick."

Like most parents with the first baby, they were giving Gloria far too much attention. They were overprotecting her; keeping her too warm, so that she had a prickly heat rash; fussing over her when she whimpered; picking her up and holding her. Undoubtedly they had communicated some of their anxiety to Gloria, who was learning that she could get attention when she cried. This happened despite her parents' previous resolution to rear their child according to modern methods. They needed reassurance, however, that she was not a sick baby. The nurse found that her temperature was normal. She was taking all of her formula and not vomiting. Her abdomen was soft. Her bowel movements were of normal consistency and number. She had gained four ounces. She showed no evidence of pain and stopped crying immediately on being picked up, so the nurse felt that she could give this reassurance to the parents.

In the previous discussion of sleeping arrangements, the reason for the baby having her own bedroom had been discussed. Mrs. Schmidt had enthusiastically rearranged her home to turn the dining room—which was rarely used—into a nursery. But when the baby was home from the hospital they were afraid to have her sleep alone and kept her in their room. Both got up to give her the two o'clock feeding and they rose every time she stirred or made a sound. From lack of sleep, they were mentally and physically fatigued, overanxious, and unable to view their own actions objectively. A calm and friendly discussion with both parents helped them to see what was wrong.

#### GLORIA RESPONDS TO NEW REGIMEN

They decided to adhere to their original plans in caring for her, and several

changes were made in their regimen. They would keep Gloria in her own room the greater part of the twenty-four hours and take turns in feeding her on alternate nights. In this way each parent could have unbroken sleep every other night. They started immediately on this program and it was gradually successful. As the baby received less unnecessary attention she demanded less.

At six weeks Gloria was the kind of baby her parents had hoped she would be—placid and happy, sleeping twenty out of the twenty-four hours, eating well and developing normally.

The mother on her sixth-week examination by her physician showed a normal involution. She had become very skillful in handling the baby and had so far forgotten all previous fears in regard to the baby's care that she was planning on purchasing a "bathinette."

The family are receiving treatment from the family case-work agency which is helping the mother work toward a more complete solution of her emotional problems. This adjustment is strengthened by the reassurance of having given birth to a healthy, normal baby, which she is capable of caring for. The nurse will continue to coöperate with the worker in every way possible and since the baby will continue to be visited by the nurse as a part of the agency's infant health service the whole family will have the benefit of health supervision for many months to come.

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## Bennington College Health Service

By HILDEGARD E. PEPLAU, R.N.

**A college health service which develops its program in line with the aims of a progressive school for higher education**

ONE of the aims of Bennington College in Bennington, Vermont, is to educate students both as human beings and as citizens. In the words of the College Bulletin: "The tradition to which we belong has as its core respect for and reliance on the individual; and active participation, not passive obedience, as the central obligation of citizenship in a democracy." The Health Service patterns its policies accordingly. There are no so-called hygiene courses. However, when students have a problem in relation to their own health or that of the community, the experience is used as an approach to health teaching. The entire Health Service staff has a teaching responsibility in addition to its treatment functions.

Two resident physicians and two full-

time nurses comprise the Health Service. One physician serves as part-time college psychiatrist, the other as part-time attending physician. One nurse acts as executive officer and serves as a clearing house for information; the second assumes complete responsibility for nursing care of all patients admitted to the infirmary. A part-time secretary and a full-time maid are employed for clerical and housekeeping duties.

The Health Service is centrally located in the Commons (Main) building which also houses the general store, post office, theater, dining halls, and other services. The medical unit is equipped with offices, a separate suite for the psychiatrist, a treatment room, and a ten-bed infirmary which can be expanded to twenty beds. Facilities for a greater number of patients are located nearby in case of an epidemic.

Bennington College enrolls approximately 270 women students. Each stu-



dent pays a yearly health fee of \$25. The entire sum is used for medical purposes—drugs, supplies, maintenance of the infirmary, and part of the salaries.

#### ADULT APPROACH TO ILLNESS

All first-year students are given a general physical examination, including a blood test. This opportunity is used to acquaint the students with both physicians and encourage them to return when they wish to discuss their physical or emotional problems. One-hour appointments are made with the college nurse. At this time certain measurements and tests such as height, weight, vision tests, urinalysis, and a hemoglobin test are made. Blood counts, basal metabolism tests, and smears are taken when the examining physician decides they are indicated. However, any student who is ill or is especially interested may request laboratory tests and observe the procedure. Opportunities to observe the nurse perform these tests and to discuss the findings with her give the student knowledge which minimizes fear, promotes effectiveness of treatment, and leads to the development of an adult approach to illness.

Students are told their diagnoses insofar as it seems wise. Drugs and treatment are explained, as well as the student's temperature and other symptoms. All students are expected to take at least one course in science at some time during their first two years. This may be a course such as human biology, comparative anatomy, drugs, or disease. The nurses frequently attend these classes and participate in the discussions.

Routine physical examinations are not given during the second and third years. However, rechecks are made if indicated or if requested by students or faculty members. All graduating students have a complete physical examination. At this time the student's health record during college is summarized. She is given assistance in planning a preventive medi-

cal program to meet her individual needs. Periodic x-rays are advised for those who react positively to tuberculin tests, blood tests for those who have been anemic, and regular eye examinations for those who have showed increasing myopia on Snellen tests.

#### TUBERCULOSIS PROGRAM FOR ALL

In the fall of each year, the nurses give P.P.D. (purified protein derivative) tuberculin tests to all new students and all students whose previous reactions were negative. The State Department of Public Health holds a one-day x-ray clinic at the college. Students who show their first positive reaction to P.P.D. tuberculin are given an x-ray which is included in the health fee. Those who have previously reacted positively are urged to have another x-ray at their own expense. The rationale of this tuberculosis program is explained to the student and the responsibility for following the suggestions left to her. Faculty and staff members are urged to avail themselves of the x-ray service. All food handlers are required to have x-rays yearly. The employee and Health Service share this expense.

Students may receive typhoid fever inoculations, vaccinations, and Schick and Dick tests without charge. Those who plan to travel during the summer are urged to avail themselves of these preventive measures. Immune globulin has been given to students exposed to measles.

#### DIETS FOR THIN AND PLUMP

A regular weight check is made every six weeks, and any diet recommendations are made and supervised by the attending physician. Students who are thin and wish to gain weight may call at the Health Service twice daily for a glass of milk and cream. Students who are overweight and want advice on losing weight are directed to the physician. A diet is planned for these students by selecting

First aid classes make Bennington students ready for any emergency



items in the regular menus. The diets, including caloric values of each item, are listed beside the regular menu and posted daily. We find that the obese student not only loses weight, but she learns the kinds and the caloric values of foods which will help her to do so. Thus when college is not in session she is prepared to continue the diet without receiving special attention.

Six days of free care in the infirmary are allowed each year. For additional service, the charge is three dollars per day. A student may seek admission to the infirmary on her own statement of illness, or may be urged to come in by the nurse in the dispensary, fellow students, or faculty members. No student is refused admission even though the nurse may recognize that she is not physically ill. There is a surprisingly low percentage of admissions of this sort. The college does not permit students to remain in the dormitory when ill and nurses do not render professional service outside of the Health Service except in real emergencies. Reporting of illness is a student responsibility and there is no penalty for not doing so except pressure of fellow students, and sometimes,

prolonged illness. Every effort is made to hospitalize students early in the course of their illness—no matter how slight—to help teach them the value of rest in bed, proper care in prevention of the spread of communicable disease, and prevention of complications, particularly following colds. Many times it is not possible to convey the value of preventive care to freshmen. These same students in their third year come in quite frequently and ask to be admitted because they feel it is "silly" to try to do their work half-heartedly as well as to expose their classmates.

Bennington offers its students an optional health insurance policy to cover medical and hospital expenses in addition to those covered by the \$25 health fee.

The absence of organized sports, rigid campus rules, and "lights out" regulations make it necessary for each student to plan her schedule to include sufficient hours for rest and play, as well as work. Frequently it is necessary to help freshmen with their schedules. Overfatigue is common in this group. It is less so in second- and third-year students, and rarely occurs in seniors.

(Continued on page 581)

# What Is an Examination ?

By CECIL R. BROLYER

What do we mean by an "examination"? What is the purpose of a formal merit examination? This is the first of two articles on uses and limitations of examinations

**B**ECAUSE of a growing awareness of the part that public health plays in the lives of us all, the next few years will probably show a material increase in the number of public health nurses connected with official agencies. And because one requirement that an official public health agency must meet, to be eligible for federal funds, is that its personnel be hired and retained in accordance with an approved merit system, it is likely that public health nurses as a professional group and as individuals will in the future have an increasing amount of experience with formal merit examinations.

There are several reasons why public health nurses should know how selection and appointment of personnel should be made under merit systems. In the first place, the nurses as a group should be interested in seeing that the methods of selection result in the appointment of persons whom the profession recognizes as the most competent of those competing for the jobs. In the second place, the individual members of the profession are members of the tax-paying public, and they have the obligation to do all they can to ensure that they as taxpayers receive an adequate return in terms of services for taxes paid. Also, the individual nurse who is competing for one of these public jobs has a very natural interest in seeing that the methods of examining are impartial, impersonal, and objective. There are many implications of the fact that under a merit system each public health nurse has the dual

role of employer and of possible employee.

In this article, the writer will discuss some of the basic concepts underlying the nature of examinations in general and of formal merit examinations in particular. Later, attempts will be made to explain some of the methods by which examination analysts try to investigate, on an experimental basis, the separate tasks of which an examination is composed and to explain some of the various forms of examinations that public health nurses will meet in connection with merit systems.

## A VALID EXAMINATION

It is probable that most of the experiences of public health nurses with examinations have been concerned with some form of school or course examination. Moreover, many of these examinations have been of the sort in which some one individual has selected a number of questions and has asked the class members to answer them. In such examinations the criteria for inclusion or exclusion of questions are ordinarily not clearly formulated. Usually they seem to partake of the form: Should a nurse know the answer to these questions? The more the nurse can repeat of what she has been taught or the more questions she can answer in accordance with the way the examiner thinks the question should be answered, the better is the grade assigned to her. Speaking loosely, the greater the percentage of nurses that answer such an examination the way the

teacher wants the questions answered, the more satisfied the teacher feels with his efforts. The interest of the examiner in such examinations is centered about the extent to which the nurses have achieved that which one examiner thinks they ought to have achieved; little interest is centered on the individual differences in ability among the nurses, and the question as to the relative superiority of the individual examinees is ignored. In a valid examination connected with a merit system, however, interest should center on the essential question: Which of each two individuals competing for this public job is the better qualified one?

As soon as attempts are made to use the results of one of these school or course examinations as a basis for saying something about the expected performance of the examinees in other situations, the following questions begin to arise: Was the examination appropriate to the subject? Was the examination a "fair" one? Was it too difficult or too easy?

#### WHAT DOES A "GRADE" MEAN?

If comparisons are to be made between performance on one examination and performance in a later situation or on a second examination, some information must be available as to the number of high and low scores made by those taking each examination. We are all familiar from our school days with the fact that a low grade in one course may be indicative of greater ability than a higher grade in a second or so-called "easy" course. We have all met such questions as, "Is this an easy or a hard course?" "Does the teacher give high grades or low grades?"

As an example, let us assume that two nurses are having an argument as to which of them really did better in their state board examinations. Let us assume that Nurse A made 75 on the state examinations that she took in 1940 and Nurse B made 85 on the state examina-

tions that she took in 1941. Nurse B is insisting that she did better than Nurse A because her grade of 85 was 10 "points" higher than Nurse A's at 75. But Nurse A points out that the highest grades given in her examination were 80 and 75, and that the remainder ran down as low as 45, whereas when Nurse B took her state examinations the grades ran from 65 to 100, with 10 nurses ranking above 85. With no further evidence than this regarding the differences in the examinations, the argument could go on interminably.

Somewhere in the consideration of these two examinations, the nurses might have recourse to the questions that each took, trying to decide which questions were harder without paying any attention to what "hard" meant. Or Nurse B might argue that the grades in 1940 were lower than in 1941 because a poorer group of nurses had taken the examinations in 1940 than in 1941; to which Nurse A would probably not agree!

Out of this imaginary analysis of state examinations, we find these questions arising: What is meant by "doing better" in examinations? How is a rational decision to be made as to whether the examinations themselves are comparable? How can it be determined whether the evaluation of the nurses' answers in 1940 was comparable to the evaluation of the nurses' answers in 1941? How could it be determined whether the group in 1940 was as good a group as that in 1941? What is meant by "as good a group as?" Who is to say whether the two groups of nurses were or were not comparable?

If the two nurses continued their argument, it is possible that eventually they might want to organize their answers to these questions into a logical, rational system. The development of such a system would require a long time, a great deal of thinking and discussion, and probably much modification of undefined terms. Although their system

would probably be satisfactory to themselves when they had it finally developed, it would in all likelihood mean little to nurses who had given no thought to what examinations really are. It would be likely, however, that the discussion of written examinations would extend to other forms of examinations and to the fundamental question, what really is an examination? Two definitions could be: *An examination is any means of arriving at a judgment about another individual, or, any means of arriving at a judgment about another individual is an examination.*

#### DEFINING "EXAMINATION"

The writer suspects that in the attempts of Nurses A and B to explain their own definition, they would have some difficulty with the phrase "to make a judgment." At the present time this phrase "the judgment of one individual about another" is probably the undefined term beyond which we cannot go. Attention might better be directed toward the questions: Who should make the judgments? How can the judgments be combined? What meanings can be attached to these combinations of judgments? How can the individuals who are to make the judgments be aided to make judgments that will be meaningful and satisfactory to an ever-increasing number of other and equally competent individuals making analogous judgments?

#### WHOSE JUDGMENT?

The question as to whose judgment is to be the basis of the examination is an important one. The writer would like to take the two following postulates as basic to the development of examinations:

1. The basis for the rational development of examination material in a given field is the judgments of workers within that field who are judged as competent by their professional workers.

2. Only members of a given profession can sense (a) differences in degrees of competence of individual performance within that professional field (b) the quality of the performance that shall be considered as just satisfactory.

It would seem to the writer that, regardless of the energy expended in attempting to define public health nursing, it will always remain the sum total of professional activities of those individuals who call themselves public health nurses and who are recognized and accepted as public health nurses by other individuals calling themselves public health nurses. Such a statement recognizes implicitly that there is always going to be an area in which arguments occur. Is this activity public health nursing, or is it not? Should public health nurses be doing this or should they not?

In discussions as to what is or is not proper content of professional examinations, these controversies will be reflected in arguments as to whether certain questions should be included or omitted and as to what should be the purpose of the examination. It would be more productive of results if discussion centered around the question, "What are the professional activities in which competence is to be predicted by the examination?"

#### WHAT DEGREES OF COMPETENCE?

Let us assume that Nurse A and Nurse B have prepared a trial examination which in the judgment of other public health nurses contains questions appropriate to the subject and which they hope will indicate degrees of competence in the examinees. As an experiment, they set up several types of questions or items. On investigating the results, the examiners would in all probability find that the nurses as a group did not respond as expected, that some of the carefully thought-out questions were missed by all the examinees,



thus being too hard for all and therefore useless as examining devices. Similarly, some questions would be too easy and so would be "passed" by all. Only a small percentage of the questions or items would prove to be of the type to distinguish *degrees* of competence in the examinees.\*

At about this stage in the development of their ideas about examinations, it is likely that Nurse A and Nurse B would have begun to raise questions as to the meanings that could be attached to the grades 75 and 85. Neither the symbol 75 nor the symbol 85 has any immediate significance in and of itself. The employer might wish to ask at this point: "Would the nurses to whom the symbol 85 would be assigned give, on the average, better professional performance than would the nurses to whom the symbol 75 would be assigned?"

At this stage it would be well if the nurses would agree that the principles underlying the construction and interpretation of examinations and the criteria by which examinations are evaluated should be essentially the same regardless of the format of the examination, its purpose, and the field covered. This statement should hold, regardless of whether examinations are written or oral, essay or objective, formal or informal, and whether they are personal interviews or evaluations of training and experience.

#### PURPOSE OF MERIT EXAMINATION

A competitive merit examination should be designed to answer the question: To which of two or more competitors should a certain public position be offered? An examination for professional licensure should, on the other

hand, be designed to answer the question: What people should be allowed to practice this profession, or which of the people taking the examination possess at least that minimum degree of competence that the profession recognizes as necessary to perform professional services? The examination for licensure makes a contribution to the competitive examination in that it should aid in answering the question: What people should be allowed to compete for a certain public position?

Both merit examinations and examinations for licensure are subject to the same types of criteria of usefulness, namely, reliability and validity. The nature of the professional service against which performance on examinations should be checked might be different in the two cases, and the concepts of passing as applied to the two examinations might be different.

A merit examination consists essentially of a series of tasks that the competitor has to perform set up in the form of questions. From a competitor's performance on these tasks, inferences are drawn with regard to the future performance of that individual. In evaluations of training and experience these tasks are vague. The tasks occurred in the past and have by no means been the same for any two competitors. The inferences as to future performance are ordinarily expressed, albeit rather unconsciously, in terms of numerical symbols that are assigned to these varying types of past experience or performance. The higher of two of these numerical symbols should indicate that the person to whom it is assigned will perform on the job more competently than the person to whose experience the lower number is assigned.

#### ORAL EXAMINATIONS

In oral examinations the task of the competitor is ordinarily to make some oral response to an oral request of an

\*At the recent Biennial Nursing Convention in Chicago, the Merit System Unit of the American Public Health Association attempted to get some preliminary information on a few types of examination items. The results of this preliminary investigation will be reported in a later issue of this magazine. (See page 599.)

examiner. To the oral response of the competitor a numerical symbol is assigned, and this symbol is used as the basis of the same type of inference as in the case of an evaluation of training and experience.

More investigations have been made of oral examinations than of evaluations of training and experience, but there is still quite a divergency of opinion as to the efficiency of the oral examination. Part of the controversy undoubtedly lies in a divergency of opinion as to the sorts of competitors to whom the public job should be offered as well as to a lack of agreement with which examiners evaluate the oral performance of the same competitor.

#### OBJECTIVE VERSUS ESSAY TESTS

If the examination is a written one, it may be of the objective form, the essay form, or a combination of these two forms. The distinction between "objective" examinations and "essay" examinations is more apparent than real. Two earlier articles\* in this magazine have dealt with the differences between these two types of written examinations in greater detail than is included here. The term "objective" is ordinarily applied to that type of examination material in which the scoring or evaluation of the competitor's responses is essentially clerical rather than professional. The term "essay" is ordinarily applied to that type of examination material in which the evaluation of the competitor's performance or responses requires professional knowledge and skill. The professional acumen which in an essay examination should be applied to the evaluation of the competitive answers should, in an objective examination, be applied to the development and selection

of the items of which the examination is to be compiled.

In the objective examination the competitor selects one of a number of possible answers or at least formulates a simple answer that can easily be classified into one of two categories, usually "right" and "wrong"; in an essay examination the competitor ordinarily formulates in his own words a rather complex answer that is assigned one of several degrees of value. In the objective examination the competitor is definitely restricted in the number of responses he can make; in an essay examination he has almost unlimited freedom of action in the formulation of his answer. Both the objective and essay merit examinations are valid or invalid only to the extent they can or cannot be used as bases for predicting later performance of competitors.

It should be noted that the means by which someone arrives at a decision as to whether these competitors do or do not perform satisfactorily on the job is after all another examination, even if it is an informal one. The basis of it is, of course, the judgment of one person about another.

In a later article the writer will attempt to explain the ways in which an examiner can attempt to formulate more efficient examination items. As these separate tasks, items, or questions become more efficient they can be combined, in such a way that the final inference drawn with regard to the future performance of a competitor is more satisfactory to a larger number of individuals.

#### SUMMARY

In summarizing this article the writer would like to stress the following points. Any method of arriving at a judgment is an examination. The merits or demerits of any examination can be determined only by means of a planned investigation. Somewhere in the background of

\*Porter, Elizabeth K. "Criteria of a Good Examination." *PUBLIC HEALTH NURSING*, September 1940, p. 558.

Uphoff, H. F., and Richardson, M. W. "The Construction of Objective Tests." *PUBLIC HEALTH NURSING*, August 1941, p. 449.

every examination is a subjective opinion of some person or of a group of persons. Merit examinations should not unduly reflect the opinions of any one person.

The meaning of any particular performance on an examination is relative; it is not absolute. This meaning is dependent upon (1) the performance of

other individuals in the examination (2) the content, nature, structure, and scoring system of the examination (3) the extent to which performance on the examination agrees with a second, and experimentally independent, index of performance or achievement in the field of the examination.

### College Health Service

*(Continued from page 575)*

A joint Health Committee comprised of four students and the two physicians and two nurses was formed in 1939 to aid in relations between staff and students. It meets periodically to discuss community health. Students voice opinions on the management of the Health Service and offer criticisms and suggestions. Misunderstandings are explained. The Health Service recognizes the value of these discussions and adopts student suggestions which do not interfere with fundamental policy in the general medical field. In this way, better student co-operation and friendly interest have been developed.

The executive officer of the Health Service is a permanent member of the College Council, made up of the heads of all college committees, which meets weekly to discuss community problems. The chairman of the Health Committee serves on the Council for the term of her office. Problems of health raised at these meetings are taken to the health staff, the Health Committee, or the students around whom the problem centers.

### COLLEGE DEFENSE PROGRAM

The college program of civilian de-

fense likewise involves the Health Service. The nurse who is executive officer is in charge of first aid and teaches two classes at the college each week. The second nurse teaches a class in the town of Bennington. Twenty-six students have completed the instructor's course and have taught classes in the town of Bennington. A weekly instructors' seminar is conducted to help them with their teaching problems. Some of these students and a trained air-raid warden comprise a first aid squad which will be in charge of all first aid in case of wartime emergency on the campus.

Not the least useful of the nurses' activities are the many informal discussions with students about their plans for the future and their winter field period projects. The winter period is planned to offer students an opportunity for independent work which can be carried out more effectively away from the College and lasts usually from Christmas to Washington's birthday. Students planning to enter medicine, nursing, and public health, and those writing papers on medical subjects come to us for help. The nurses of necessity read current literature and find winter field period and summer positions that will keep them abreast of the times in the fields of medicine and nursing.



## Familiar Black Bag---Homemade Variety

By HARRIET ULRICH FISH

**A**FTER a reserve corps of volunteer public health nurses had been secured by the Seattle Visiting Nurse Service as a part of the city's emergency medical service, the agency was confronted with the problem of providing working equipment for perhaps as many as 50 volunteers.

Leather bags were out of the question because of the expense, and a substitute had to be devised. The local Red Cross chapter was willing to contribute \$700 to the Visiting Nurse Service for equipment and supplies to be used in a pos-

sible disaster, but it was realized that most of this money would be needed for nursing supplies and should not be used for bags. An improvised bag was therefore designed which could be made by volunteers for a moderate cost.

A lightweight wooden box was converted into a substitute nurse's bag of standard size, which should serve very satisfactorily. Completed bags cost about 60 cents each. (There may have been some increase in prices since this was written.) The remainder of the money is available for supplies—aprons, com-

### *Materials for one bag*

- 1 wooden box—12" x 6" x 6"
- 1 wooden lid—12" x 6" x  $\frac{1}{8}$ "—thin but strong
- 1 piece black oilcloth for cover—30" x 24" plus  $\frac{3}{4}$ " allowance for each seam (Diagram E)
- 1 piece muslin for lining—30" x 36" plus  $\frac{3}{4}$ " allowance for each seam (Diagram F)
- 2 pieces muslin for lining pockets—9" x 10"
- 4 double 4" squares of oilcloth for bottom corner protectors (Diagram A)
- 1 strip oilcloth for handle cover—64" x  $1\frac{3}{4}$ "
- 1 strip heavy canvas for handle lining—64" x  $1\frac{3}{4}$ "

- 14-16 thumbtacks, short shanks
- 8 1" flat-headed brass paper fasteners
- 8 1" square pieces of heavy cardboard for reinforcing (or 8 No. 2 brass "paper fastener washers")
- 12 inches of shoelacing type of cord for hinges

### *Tools*

- Drill (brace and  $\frac{1}{8}$ " bit)
- Hammer
- Scissors
- Paper stapler which will open out flat
- Sewing machine heavy enough to stitch oilcloth
- Black and white thread

municable disease gowns, home delivery equipment, incubators, and many other much needed items.

The district volunteer committees of the Service made the bags, linings, muslin bags for supplies, aprons, and communicable disease gowns. They folded the gauze for dressings and wrapped them for sterilization. They also collected the bottles in which to carry liquid soap and alcohol. As a result of their efforts we now have 50 improvised bags fully equipped for use by volunteer nurses in the event of a disaster or a sudden increase in service. Many hours of experimentation are behind the finished product, and perhaps other organizations might be saved this time and effort by following our pattern. The materials used, the necessary tools, and methods of construction of the bag are outlined as follows:

1. Cut squares to fit smoothly. (Diagram A) Use 2 thumbtacks at each corner, setting firmly with hammer. (These oilcloth pieces come from scraps left over in cutting.) Thumbtack double squares of oilcloth to bottom 4 corners of box.

2. Drill 2 holes at upper edge of long side of box and 2 matching holes on long side of lid—each 3" in from short side and 1" down from long edge. (These will constitute the hinge apparatus later as in Diagram D.)

3. Drill 4 holes through bottom of box to hold handle firmly to bottom. (Diagram B)

4. Drill 4 holes, 2 on each long side of the box, to hold handles securely and uprightly. (Diagram B)

5. Cut cover of box according to Diagram E. The easiest way is to cut the pattern from wrapping paper and use it as a cutting guide, first laying it in the position to get the most from the material and then drawing around it.

6. Fit cover to box, inside out, by pinning the 4 corner upright seams. Then fit the flap of material around the lid like an envelope, leaving just enough mate-

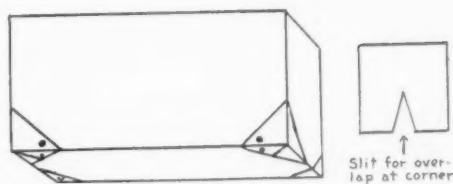


Diagram A

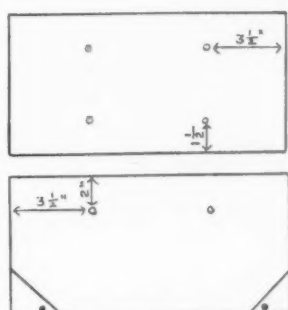


Diagram B

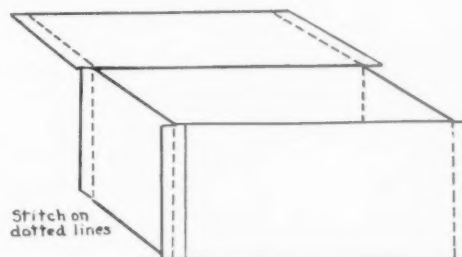


Diagram C

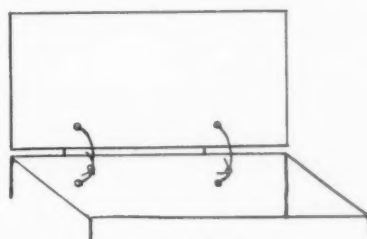


Diagram D

rial to allow free swinging of the hinge at the joining of box and lid. (Diagram C)

7. Stitch these pinned seams with rather widely spaced stitches and turn right side out.



8. Slip cover onto box and slide the lid into the envelope section formed by the stitching. Be sure the side with the holes is adjacent to the box.

9. Now is the time to put the lacing through the hinge holes. Make a complete circle and tie the ends with a hard knot (square knot—you first aiders!). (Diagram D)

10. Raw edges of oilcloth now stick up around three edges of the open box top. These can be thumbtacked securely on the top edges or better still stapled through the cloth and into the wood. The excess cloth on the inside of the lid cover can be turned in and stapled to the lid.

11. The handle must be made next. Turn the raw edges of both oilcloth and canvas in so that the right sides are outside. Pin them together and stitch on both edges. The oilcloth will form the top side and the canvas the under side. Finished handle should be about 1 inch wide. Join the ends together by stitching so that it forms a continuous flat band.

12. Now those holes which were drilled in the bottom and sides of the box will be used. Push a paper fastener through the center of the handle, then through a piece of cardboard, and finally through the oilcloth cover at one of the bottom holes, and split fastener on the

inside of the box bottom. Similarly the matching hole on the same end of the box will have a paper fastener attaching the handle in the same way. The two side holes on the same end can also have the fasteners attached. Then the remaining free section of handle must be divided equally to have the holding parts of equal lengths. Fasten the handle to the other 4 holes in the same way.

#### LINING

1. Cut main lining and 2 side pockets by means of a cutting guide in the same manner as for outside cover, allowing  $\frac{3}{4}$ " extra for seams. (Diagram F) (In order to get the most from the material, the narrow sides and flaps can be cut separately and stitched on during the assembling. If this is done, be sure to leave seam allowance.)

2. Fold the 2 side pocket pieces and stitch to the lining, being sure to place them about  $\frac{3}{4}$ "-1" from the box bottom on the material. Stitch one on 3 sides only and the other with instrument sections according to Diagram F.

3. Stitch up the sides (about  $5\frac{3}{4}$ ") leaving the protecting flaps free to cover the contents or to be thrown back easily. The edges of these flaps can be hemmed by machine to make a neat job complete.

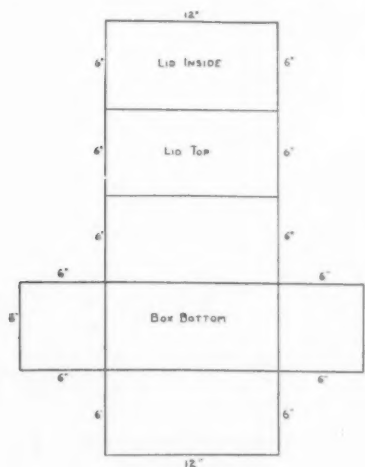


Diagram E

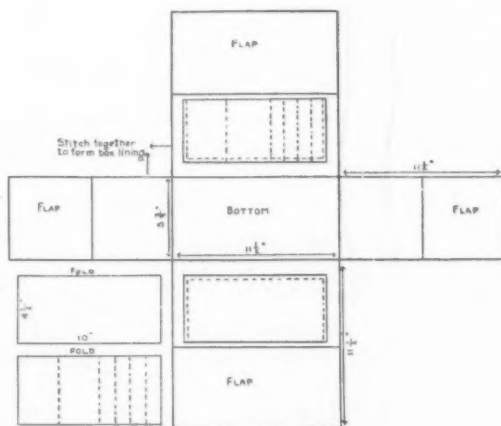


Diagram F

# Policies in Industrial Nursing by V.N.A.'s

By DOROTHY E. WIESNER

**I**NTEREST in nursing service offered to industries by public health nursing agencies has been greatly stimulated by the war production effort and the great importance of protecting the health of workers.

A summary of information about industrial nursing service made available by visiting nurse associations was published in the December 1941 issue of *PUBLIC HEALTH NURSING*. (Page 735.) The data were secured from a postcard inquiry sent to a selected number of non-official public health nursing agencies. About three quarters of the 260 agencies to whom the postcard was sent returned answers, and about 30 percent of those who answered reported they were active in the field of industrial nursing.

A four-page schedule was sent in January 1942 to 59 agencies who had thus replied. Data were requested about: (1) type of establishment served, e.g., factory, bank, telephone company (2) extent of industrial nursing service (3) methods of interesting establishments in part-time nursing service (4) types of nursing service offered to plants (5) relationships between nursing service and plant (6) amount of time and payment for service (7) compensation and other record work (8) preparation of nurses for industrial service.

Only 22 of the 59 agencies returned the four-page schedule. Thirty sent no reply whatever, and 7 wrote that their industrial nursing program was not the kind about which the requested information could be given. A number of agencies had misunderstood the original postcard question: "Have you any individual contracts with local industrial or

commercial firms to supply nursing service?" and thought it meant home visits to workers covered by a group insurance policy. Such service is more usual than is the supplying of part-time nursing service in the plant. It is the latter kind of service which was of interest for this report—the *individual* contract with the *local* firm. However, some agencies offer both types of service, in which case information on both may be included here.

## 1. *Type of establishments served*

Thirteen of the 22 public health nursing agencies reported a contract with one establishment; 3 reported contracts with 2 concerns; 2 reported contracts with 3 factories; one reported a contract with 4 companies; and 3 reported contracts with 5 companies to whom service was given. Thus there were 44 establishments receiving service from the 22 public health nursing agencies.

The types of establishments varied widely. Metal industries, of which there were 10, were the most numerous. Five were mercantile organizations or firms employing office workers, and 5 were food or drink concerns. There were 3 paper mills; 2 laundries; 2 plants that made roofing materials; and 2 textile factories. Among the other types of plants were an airplane factory, a radium concern, a tobacco factory, and a wood-working plant.

Five of the establishments employed over 700 workers each. These were a company making artificial teeth, a machinery concern, a meat-packing firm, a company making metal products, and a paper mill. Four plants employed between 500 and 700 workers. These were a paper mill, a gear-manufacturing plant, a textile factory, and a firm mak-

ing radios. Nine establishments employed from 300 to 499 workers; 17 employed from 100 to 299. Seven plants employed less than 100 workers. They were an advertising firm, a bank, a bakery, a candy plant, an electric light company, a lumber firm, and a firm of wall-paper designers. In 2 instances the number of employees was not stated.

The dates at which industrial nursing service to these 44 plants was started by the visiting nurse associations indicate the recent growth of such service. In 19 establishments the work was begun after January 1, 1941. However 6 plants had had the service before 1930. In 11 concerns the nursing service began between 1930 and 1934. Five began the service in the period from 1935 to 1939; 2 began it in 1940. The date at which one service was started could not be determined.

### *2. Extent of industrial nursing service*

The number of nursing hours a month in each establishment was of interest. Only 3 agencies—reporting on service to 7 plants—said their industrial nursing service was given exclusively outside the plant. For 5 plants, the number of nursing hours a month in the plant was not stated. Among the 32 plants for which data were available the amounts of time varied from 4 hours a month in a California electric globe concern to 218 hours a month in a New York metal-producing factory. The former paid on an hourly basis, and the latter paid salary of the staff nurse plus \$10 a month for supervision.

Home visiting was not of major importance in the industrial nursing program of most of the agencies. In only 2 plants were 50 or more home visits a month made to workers. One of these was a Pennsylvania paper mill employing more than 500 workers, in which the village revolves about the mill. The other was the California airplane factory, in which home visits were paid for

by a separate insurance contract. For 16 plants there was no information given concerning home visits. Probably for most of these the agreement with the plant did not include home visiting. In seven plants no home visits were made by the nurse. For 11 plants, less than 5 visits a month were reported; for 6 plants, between 5 and 9 visits a month; for 2 plants, between 21 and 27 a month.

In no company was a full-time physician in attendance in the plant. Eight establishments employed a part-time physician. In the others, either the physician was on call or no data were given about his services.

Thirty-five plants had standing orders, although in a mattress factory in Massachusetts these orders were the usual "D.N.A. orders" used with consent of the medical advisory committee. Only 2 factories had no standing orders in force. For 7 plants, no data were given about standing orders.

The amounts per month paid by the 44 plants do not make part-time industrial service attractive as a source of income to the agency. Only 8 plants paid \$50 or more a month, in amounts ranging from \$50 to \$173. Nine establishments paid the visiting nurse associations less than \$10 a month; 14 paid from \$10 to \$29; five paid from \$30 to \$39; three paid from \$40 to \$49. For five plants, the amount was not stated.

### *3. Methods of interesting establishments in part-time nursing service*

Especially interesting were answers to the question as to how agencies approached industrial establishments to present the possibility of giving part-time nursing service. Methods followed by a visiting nurse association employing 6 nurses in a Michigan city seem to be successful since the agency has started service in two metal-working plants since September 1941. Its procedure is outlined here:

1. V.N.A. secured standing orders approved by the industrial committee of the county medical society.

2. Interviewed key person explaining program, records, reports.

3. Visited plant and arranged for first aid station. Plant arranged first aid.

4. Drew up contract—including hours, rate, duties of V.N.A., nurse, and plant.

5. V.N.A. board took out a membership in the National Safety Council.

Detroit's methods have been successful also. The Visiting Nurse Association has opened service in five plants since February 1941. Steps in obtaining contracts were given as follows:

1. Announcement of industrial service in newspapers, trade papers, labor union papers, medical bulletins.

2. Letters to selected plants.

3. Personal interviews for nursing representative, arranged for by a board member known to the plant executive.

4. Personal interview with plant officials and plant physician.

5. Completion of contract for visiting nurse service, signed by plant executive and executive of V.N.A.

Another large city agency reported a variety of ways in which industries were informed of its service. The president of one company was referred to it by a university. A second plant—a metal industry—asked the nursing agency where men nurses could be secured, and thus opened the way for the association to supply part-time nursing service for helping with physical examinations and first aid. The full-time nurse in a third plant asked for assistance from the agency. All three of these services began in 1941.

The Visiting Nurse Society of Philadelphia, serving five plants since 1932, reported the following method:

The Society was requested by the Philadelphia Health Council and Tuberculosis Committee to take over a group of five plants which were part of the Association's demonstration of industrial health service for small plants. Two plants, which had also been in the demonstration, have been added since at their own request. Two plants have with-

drawn—one left the city, and one installed a full-time nurse—leaving a total of five.

Industry made the first move toward getting nursing service from the agency in one town. The Visiting Nurse Association reported:

In this town the paper mill took the initiative in the employment of a nurse, and worked out a co-operative agreement with the village.

In one city, the service was requested by the branch factory of a firm which had part-time nursing service in its Philadelphia factory. The 1918 influenza epidemic was mentioned by another agency as stimulating interest in the introduction of industrial nursing service. Two cities reported that the industries formerly had group insurance policies, then dropped the insurance but kept the home visiting service. One smaller agency reported that a mattress company donated a crib mattress to the association, and through that contact, interviews regarding the service began. In two New England plants the employer approached the local visiting nurse association and asked for the service. In four other cities, the association made personal contact with the superintendent or manager of the plant.

Apparently visiting nurse associations in the past have generally taken the initiative in offering service to the industrial establishment. This may be changed, however, because of increased needs for industrial health work. It is significant that the Committee on the Development of Industrial Hygiene in Local Areas of the National Conference of Governmental Industrial Hygienists recently passed a resolution suggesting that "state and local divisions of industrial hygiene assume the leadership in developing part-time nursing services in small industries" and outlining a plan of procedure which could be used as a guide in developing such part-time service.\*

\*"Part-Time Nursing in Small Industries." PUBLIC HEALTH NURSING, June 1942, p. 330.

#### 4. *Types of nursing service offered to plants*

Eleven phases of industrial health work were listed in the schedule as possible activities of the nurse in the plant. Eighteen of the 22 agencies reporting gave usable data about their program in each plant. The activities, and the number of agencies reporting them as part of the program in one or more plants, were as follows:

ACTIVITIES OF NURSES FROM VISITING  
NURSE ASSOCIATIONS IN INDUSTRIAL  
ESTABLISHMENTS

Activities of nurse in industrial establishments as stated in the schedule	Number of agencies reporting each activity
Advice and assistance to employees in securing correction of physical defects and social maladjustments	18
Record keeping	17
First aid and subsequent nursing care under direction of a physician	17
Health education by individual conferences	15
Bulletin, display posters, et cetera	12
Inspection of industrial establishment	11
Participation in safety program	9
Assistance to the physician in conducting physical examinations	8
Advice to the manager of the lunchroom	5
Group conferences or classes	4
Assistance in developing recreational facilities	1

In reply to the usual question, "other services to the industry," only one agency named an additional service, "visits of staff nutrition and case-work consultants to plants."

#### 5. *Relationships between nursing service and plant*

The plant official to whom the agency nurse was most often responsible was the personnel manager or director. This was true in 10 plants. In 7 concerns she was responsible to the president or vice-

president. In 7 others she was responsible to the physician, although in 5 of these the nurse reported to both the physician and one other official—either the plant superintendent or production manager. In 6 factories, she was responsible to the superintendent of the plant, and in 4 others the word "manager" was used. In one case, an electric light company employing 85 workers, she was responsible to the president's secretary; in another, the airplane factory, to the director of welfare; and in another, to a "director." In 7 instances this information was not given.

Both oral and written reports by the nurse to the management were made in 10 plants; written reports only, in 16 instances; oral reports only, in 8 plants. Only one agency stated that no periodic reports were made, although for 8 plants there were no replies to this question. The part-time nurse in the plant which used visiting nurse service at the request of its full-time nurse reported through this nurse.

#### 6. *Amount of time and payment for service*

Three of the 22 nursing agencies reported that the amount of time given in the plant was determined experimentally. Two used the estimated needs as stated by the National Association of Manufacturers\*—2 hours for each 100 employees. Two said the amount of time was set by conference and mutual agreement. One large agency originally planned to supply 20 hours weekly for a plant of about 400 employees, but has given more than this time while plants have been expanding so rapidly. Another agency stated that as the service grew the agency provided more time. One agency reported that the firm requested a stipulated amount of time at first, based on the number of employees.

\*National Association of Manufacturers. *Who's Too Small for a Health Program?* December 1940. 11 pages.



but that the time allowed has since been increased one hour daily. Only one, in Philadelphia, mentioned the factor of hazards as influencing the amount of service. The time given by one agency was limited to what the factory could afford. Three agencies spoke of home visits as the chief work. Four agencies made no reply to this question. On the three other schedules information was given concerning the use of employees who have been trained in first aid, to supplement the time of the staff nurse in the plant.

Cost per visit was the basis for arriving at the charges for supplying nursing service to industries in eight agencies; some of these did not work within the plant. The hourly appointment charge was mentioned by seven, the charge for the first hour being about \$2. One arrived at the cost on the basis of estimates given by the National Organization for Public Health Nursing and The Visiting Nurse Society of Philadelphia. Another guessed at a cost of \$1 an hour, and later raised the charge to \$2. A third, the village agency in which the paper mill work was the most important part of its program, paid the nurse primarily for industrial work. Three did not answer this question, and one agency which had begun industrial work in 1922 did not know how the charge had been established.

Only four agencies had plans for changing financial arrangements for their industrial work. One of these, which began charging \$1 an hour, may raise the charge to \$2.50 an hour. Another said it would stabilize charges after the service was established. A third reported three ways of computing hourly costs, and will secure a cost accountant's advice on the question. The fourth reported that the factory was considering employing a full-time nurse for its work, in which case the salary basis, rather than a part-time hourly basis, would be used.

#### *7. Compensation and other record work*

In only 4 agencies were the nurses responsible for filling out compensation forms. In only 3 did the part-time nurse have ready access to other employee records, such as time and salary data, although 2 other agencies stated such records could be consulted upon request. Five agencies reported the industries provided some clerical assistance. Eleven said the nurse had no clerical assistance in the establishment, but in 8 of these instances the nurse received clerical help from the agency. Six did not answer the question in regard to record work.

#### *8. Preparation of nurses for industrial service*

A special industrial supervisor was employed by only 2 of the 22 agencies. In 6 agencies the director served as industrial supervisor, visiting the plant, and in one agency preparing monthly reports. The generalized supervisor served as industrial supervisor in 8 associations. Two agencies mentioned supervision of industrial work by the state department of health. One large agency reported that the industrial work was supervised by "administrative personnel" and that they had not yet employed an industrial supervisor.

The industrial nursing preparation of the nurses serving in the establishments was the subject of one question. Courses or classes in industrial nursing were mentioned by 5 agencies, in California, Michigan, New York, Ohio, and Pennsylvania. Reference reading and staff education programs were mentioned by 4. In 4, the only preparation was that included in the regular public health nursing course. Attendance at conferences on industrial nursing was mentioned by a Pennsylvania and a Vermont agency. Observation with a nurse in another industry was mentioned once. The nurses in 6 agencies had had no industrial preparation.

The picture may change soon with the

present development of courses on industrial hygiene in public health nursing programs of study, of summer courses on industrial health subjects, and of institutes and conferences in various parts of the country under auspices of official agencies and medical and nursing organizations.

Supervised and planned introduction to the plant, together with a university class in industrial nursing, was the way a staff nurse was prepared for industrial work in Philadelphia. The industrial supervisor there was prepared by experience both in the plant and in supervision as well as by university preparation.

#### CONCLUSION

The types of industries served by these 22 agencies located in 13 states are varied as to products made and as to

number of employees. It is to be regretted that more agencies did not return the industrial nursing schedule, and that for this reason the available information may not be entirely representative of the work by visiting nursing associations. There may have been some minor misinterpretations by agencies of information requested, and of agency answers by those summarizing them for this report. A visit to each agency and to a plant served by each agency would be far more useful than the questionnaire method, and a summary such as this cannot explain all the variations. Since the visiting is impracticable at the present time, this limited review was made to share the experience in part-time industrial nursing with agencies interested in offering more complete service by including industrial health in their community nursing programs.

#### Editor's Farewell

*(Continued from page 549)*

Its application to our field encompasses the concept of community planning for nursing service, and, in public health, appraisal and planning on a community basis to meet total needs, close gaps, and give really effective health service to our people. Despite many individual reports of co-ordinated and combined nursing services this is still almost an untilled field, even in the face of wartime shortage of personnel. Through necessity it may become one of the gains to balance many setbacks in our progress.

Mirrored also in the magazine during these years are changing concepts of why human beings behave the way they do and how conduct may be motivated and changed. Education and supervision of nurses, methods of working with families, health education in school and community—all reflect this new

understanding of human behavior.

The war, which is being fought to preserve all the social gains we have made, increasingly fills the pages of the past two years. War, however, always imperils social gains as long-time progress gives way to emergency needs. Little by little, hard-won standards of living and health and work are allowed to slip and are hard to regain later. It is important that we as nurses recognize the underlying causes of this war and the social changes it implies—that it is a stage of “the march of freedom for the common man,” a “people’s revolution,” in the words of Vice-President Wallace, to build a better society for all the people. We must keep always in mind that our real work will come after the peace, to translate into vigorous social action the goals we have long had before us.

P.P.

# NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

## CHANGES IN EDITORIAL STAFF

PURCELLE PECK, who since 1936 has been editor of PUBLIC HEALTH NURSING, in April announced her marriage to Austin J. Smith. This event would be welcomed as a happy one by the N.O.P.H.N. and by readers of the magazine but for one unfortunate fact. Mrs. Smith's future home will be in Cleveland, Ohio, which means that she will resign as editor of the magazine in October.

We are publishing in this issue a letter from the chairman of our Publications Committee in regard to Miss Peck's contribution as editor of the magazine. (Page 592.)

The N.O.P.H.N. wishes to express its thanks to its editor for a job well done and its grateful appreciation for her willingness to remain in her position until other arrangements for editing the magazine could be completed. We wish her every happiness and hope that the initials "P.P." will continue to appear from time to time in the pages of the magazine.

R. H.

FOR MANY months the N.O.P.H.N. has emphasized through the pages of PUBLIC HEALTH NURSING the need for adjustments to wartime conditions. Now it is practicing what it preaches in regard to conservation of public health nursing power by appointing a well-qualified managing editor who is not a public health nurse, Mary Edwards Shaw.

Mrs. Shaw received her baccalaureate degree at the University of Minnesota where she was graduated with honors and was elected to Phi Beta Kappa. Since graduation she has had wide experience in various fields of public health. For fifteen years, 1925-1940, she was assistant director and statistician of the

American Social Hygiene Association where she took part in numerous Association activities—statistical, editorial, public health education, law enforcement. From 1940 to 1942, Mrs. Shaw was assistant secretary of the National Maternal and Child Health Council in Washington, D.C. Among other responsibilities, she had charge of exhibits and publications, including the fortnightly factual bulletin, "Clearing House Notes." She holds a federal civil service rating as "Information Specialist."

The N.O.P.H.N. considers itself fortunate to have obtained the services of an editor so well prepared to share with the professional staff the responsibility of the magazine in this critical time.

WE ARE especially pleased to announce that Leah M. Blaisdell will act as editorial consultant on professional aspects of the magazine, serving on a part-time basis. In addition Miss Blaisdell will continue her work with the Henry Street Visiting Nurse Service, where she is assistant director in charge of personnel, and with Teachers College, Columbia University, where she has been a part-time instructor in public health nursing since 1936.

Miss Blaisdell's name is familiar to our readers because of her contributions to the magazine in recent years, as well as her outstanding work in the field of in-service education. She began her career as a public school teacher, was later graduated from the Philadelphia General Hospital School of Nursing, and received her B.S. degree at Columbia University. Prior to entering public health nursing, Miss Blaisdell had valuable experience as a hospital supervising nurse and teacher in schools of nursing.

Before coming to the Henry Street Service in 1938, she was educational director in the Division of Public Health Nursing of the New York State Department of Health.

**A**LTHOUGH the Publications Committee and public health nurses in general know that the magazine is to continue in able hands and look forward with confidence to future help from its pages, I would like as chairman of the Publications Committee to express appreciation of Purcelle Peck's work as editor of *PUBLIC HEALTH NURSING* and to comment on the kind of help which has been available to public health nurses from the magazine under her leadership.

A friend of mine once commented that she could not understand why one would choose to become a nurse, saying that the work was "so confining." Any nurse reacts to that remark with amusement. Her reaction is to tell a person who comments in that manner of the variety of nursing work the country over, differing in emphasis in various areas but as similar in fundamentals as we can make it at this time. This variety in all its wide scope has been brought to us in *PUBLIC HEALTH NURSING* by reason of Miss Peck's broad knowledge of public health nursing and her ability to see that its many phases are presented in the pages of the magazine. We have therefore had before us, month by month, an authentic and carefully balanced countrywide view of our professional field. We have been able to rely on the magazine not only for sound and detailed information in areas which needed clarification but have had before us a range of subject matter which kept us alive to our public health nursing job as a whole. Those of us who have worked closely with Miss Peck know that this was no happenstance or opportunism but was the result of the editor's able leadership in co-operation with other members of the N.O.P.H.N. staff.

May I express my own appreciation and, I am sure, the similar feeling of many other nurses, for Miss Peck's discriminating and progressive leadership during the past seven years of her editorship of the magazine.

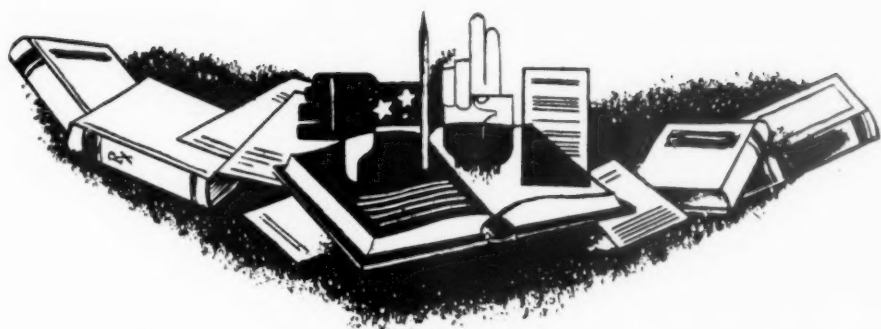
RUTH GILBERT, R.N., *Chairman*  
*Publications Committee*

#### FIELD SERVICE

**A**S THE year progresses the energies of the staff are being devoted increasingly to activities connected with the war. A number of groups throughout the country have asked for guidance and advice on their responsibilities in this emergency and in response to requests for such assistance Ruth Houlton made a trip to the Midwest. Besides individual conferences, she met with the Public Health Nursing Section of the First District of the Illinois State Nurses Association in Chicago on September 15, and spoke at the Eighth District meeting of the Wisconsin State Nurses' Association in Wausau on the sixteenth.

On August 15-16 The American Physiotherapy Association called a meeting in New York City to draw up a program for care of the handicapped during and after the war. Ruth Houlton and Mary Macdonald participated in these discussions. On August 28 the members of the Commission on Children in Wartime of the U. S. Children's Bureau, of which Miss Houlton is a member, met in Washington to take up the problems which children face.

A series of orthopedic institutes has been started in Pennsylvania, the first of which was held in Philadelphia on September 28-29 by Jessie L. Stevenson and Carmelita Calderwood. Miss Stevenson conducted two conferences on orthopedic nursing earlier in the season, one in the Department of Public Health of Flint, Michigan on August 27, and another with the staff of the Visiting Nurse Association of Detroit on August 31 and September 1.



EDITED BY EVELYN C. NELSON

#### THE STORY OF CLINICAL PULMONARY TUBERCULOSIS

By Lawrason Brown, M.D. 411 pp. The Williams & Wilkins Company, Baltimore, 1941. \$2.75.

This is a fascinating story of the historical development of tuberculosis and its treatment by medical men from the time of Hippocrates—and what is known of the period before him—to the present time. While the title might lead one to suspect that it was written strictly for physicians, such is not the case. Although it is definitely instructive, it is written in so clear and interesting a manner that it can be read with enjoyment and appreciation by anyone interested in medical progress. Public health, sanatorium, hospital, and other nurses will want to read the book, both for its information on tuberculosis and for the rich historical background of the fight to control the disease in which they, too, have a part.

HELEN LE LACHEUR, R.N.  
*Austin, Texas*

#### OCCUPATIONAL DISEASES

By Rutherford T. Johnstone, M.D. 558 pp. W. B. Saunders Company, Philadelphia, 1941. \$7.50.

This is a very important book because it supplies a great deal of clinical material on occupational diseases for the use of the general practitioner and the industrial nurse. The numerous case histories and illustrations will appeal to general practitioners and industrial nurses who

may not be interested in more technical material.

The material is divided into eight parts. The subjects covered include workmen's compensation, purposes and administration, dermatoses, occupational cancer, heat and climatic affections, electrical injuries, caisson disease, neurosis associated with trauma, malingering, and the pre-employment examination.

Certain technical errors, particularly with reference to some of the engineering concepts (both industrial hygiene and safety engineering), need not detract from the value of the book to persons who are interested in the clinical phases of occupational diseases.

The book is well indexed with references at the end of each chapter. It will be of interest particularly to physicians and nurses. Its value to lawyers, engineers, and nonmedical specialists in the field of industrial medicine and industrial hygiene will be limited because of the clinical nature of the material.

C. O. SAPPINGTON, M.D., Dr.P.H.  
*Chicago, Illinois*

#### MINERALS IN NUTRITION

By Zolton T. Wirtschafter, M.D. 175 pp. Reinhold Publishing Corporation, New York, 1942. \$1.75.

To the public health worker interested in the spread of sound nutrition teaching, a new emphasis on the long recog-



nized importance of minerals is welcome. The apparent preoccupation of many people today with vitamins alone points to a need for understanding the interdependence of minerals and vitamins, and the interrelation between all components of an adequate dietary. The aim of this book, to reaffirm the importance of minerals, is commendable. By the discussion of minerals alone, their essential functions are dramatically highlighted. But dissociating them from the natural setting in which they occur in combination with other essential nutrients, makes them appear somewhat out of focus. The book, written as it is, largely from the standpoint of physiological chemistry, needs interpretation by a technically trained person before it is of use to the layman.

CORNELIA DUNPHY  
*New York, New York*

#### PHYSICIANS REFERENCE BOOK OF EMERGENCY MEDICAL SERVICE

A compilation, chiefly from medical literature, presenting the practical experience and lessons acquired in handling civilian war casualties. 268 pp. Medical Department, E. R. Squibb & Sons, New York, 1942. Free to physicians and surgeons in the Emergency Medical Service of the United States of America. Single copies will be given to public health nurses upon request.

This is a compilation of articles from British and American medical literature. Although it is written for the use of physicians, it will be helpful to public health nurses because it furnishes a first-hand background of information from England concerning the problems of civilian casualties and civilian protection during air raids, and includes information from the U. S. Office of Civilian Defense that is of value as reference material.

Section I, Precautionary Measures, includes several articles from British sources that pertain to protection of civilians and hospitals during bombing raids. The reviewer was impressed with the report of the incidence of thrombosis of the veins of the leg due to the use of

deck chairs as improvised beds in shelters before cots were provided.

Section III, Management of Casualties, contains articles on the treatment of burns, shock, wound infections, and other surgical procedures. The chapter on shock is well worth reading by the public health nurse, since nursing care continues to be of importance. Some new concepts of the nature of shock, a discussion of primary versus secondary shock, and the recent treatments for shock as practiced in London, are included.

Some of the discussions of the newer treatment of burns are rather confusing because the opinions of the authors vary. However, a background of the various methods of treatment is given, and notes from "Treatment of Burns and Prevention of Wound Infections," published by the U. S. Office of Civilian Defense, clarify the procedures as accepted by the Medical Division of the O.C.D.

S. P. B.

#### FIRST AID PRIMER

Also including Civilian Defense Health Aids, Emergency Feeding, Blackout Instructions, and Morale Through Nutrition

By Hermann Leslie Wenger, M.D. and Eleanor Sense, M.Sc. 104 pp. M. Barrows and Company, New York, 1942. \$1.

According to the introduction, this book is intended to explain "some of the fundamental facts concerning the handling of emergencies, without the use of technical terms."

That portion of the book which is devoted to first aid covers various phases of the subject in very brief form with a minimum of illustrations. It discusses briefly some of the generally accepted methods of applying bandages, which can be found in the standard first aid textbooks. The chapter on Broken Bones is not in complete agreement with the published views of the Committee on Fractures and Other Traumas of the American College of Surgeons, especially insofar as the care of fractures of the

skull, neck, and back are concerned. The chapters on Control of Bleeding and Internal Injuries and Shock are very brief and most inadequate.

In evaluating this book, one is forced to compare it with those already available to the public. The U. S. Bureau of Mines' *Manual of First Aid Instruction*, the *First Aid Textbook* of the American Red Cross—each having about three times the number of pages of material—and the less easily available *First Aid to the Injured* of the St. John Ambulance Association of England are the accepted and approved books. Compared with these, the *First Aid Primer* is most inadequate. The reviewer has tried diligently to find something in this book to recommend, but has failed.

JOHN T. GEIGER, M.D.  
New York, New York

#### UNDERSTANDING YOURSELF THE MENTAL HYGIENE OF PERSONALITY

By Ernest R. Groves. 268 pp. Emerson Books, Inc., New York, sixth edition revised, 1941. \$2.50.

"To help the reader to know himself, to tolerate what cannot be changed, and to utilize to the full his personal and unique resources is the motive of this book."

The author seeks to accomplish these objectives by a discussion of the various facets of personality structure. He begins with the body: its build, its "chemical self," its management in the light of its needs. Then his concept of the mind is explored, both in its conscious and unconscious functioning. The influence of the cultural pattern and of childhood and adolescent experiences is brought out. Two chapters are given over to sex factors in adjustment. The last chapter deals with "a reasonable attitude toward life."

To this reviewer it would seem that too great an effort has been made to integrate widely differing schools of thought, since a unified concept is not possible and too broad generalizations

result. The book is not for the professional reader but may be of interest to the lay reader who is looking for reassurance and help on a suggestive level.

DOROTHY I. ROBERTS  
New Haven, Connecticut

#### MANUAL FOR THE CONDUCT OF CLASSES FOR EXPECTANT PARENTS

Prepared by Mrs. Ellen D. Nicely, R.N., Director of Prenatal Program, and her assistants, 168 pp. Cleveland Child Health Association, 1001 Huron Road, Cleveland, Ohio, second edition revised 1942. \$1.50 postpaid.

This manual covers organization plans, lesson outlines, record forms, and an evaluation summary of the classes for expectant mothers and fathers in the Cleveland Child Health Association. It is regretted that more recent concepts in regard to bowel and bladder training and material on instruction of the mother in the processes of labor are not included. Preparing children for the new baby is mentioned, although one would hope for more emphasis on preparation of the family as a group for the new baby. The material should have considerable value for the new nurse or the rural nurse working alone, as a guide in organizing similar groups.

E. C. N.

#### SOCIAL INFLUENCES AFFECTING THE BEHAVIOR OF YOUNG CHILDREN

By Ruth Pearson Koshuk. 71 pp. Society for Research in Child Development, National Research Council, Washington, D.C., 1941. \$1.

This monograph reviews the modern concept of child behavior and various factors influencing attitudes. It includes a discussion and interpretation of findings of many studies which have appeared. The pamphlet attempts to point out the main factors which have a bearing on child behavior and to relate the findings of the different studies so as to form a composite picture. It recommends further exploration of the many phases of child behavior.

HELEN A. CARY, M.D.  
Portland, Oregon

## RED CROSS HOME NURSING

By Lona L. Trott, R.N. Prepared under the direction of Nursing Service, American Red Cross, 431 pp. The Blakiston Company, Philadelphia, 1942. 60c.

The fifth edition of this popular book on home nursing appears with some changes and many additions in subject matter. Organized in four units, it contains a wealth of material, with inevitably some overlapping. The book is written in simple, clear style. Some of the technical procedures, such as bed-making and bathing the baby, are described in perhaps too great detail.

The unit on care of mother and baby includes a plan for a home delivery setup and the nursing care of the lying-in mother. The suggestions for improvising bathing and toilet equipment for the baby should prove helpful. The material on child care—in Unit One on Health and Happiness in Home Life—is well prepared, and includes a discussion of

foods, habit training, child development, and the environment of the child. Dr. Ira Hiscock's chapter, *How the Community Protects the Health of the Home and Family*, will do much to make clear to lay readers the activities of health departments and should bring about a better understanding of public health organization and functions. The unit on home nursing care is comprehensive and seems to be the outstanding material of the textbook. Suggestions for further reading, with lists of free and inexpensive books, are given at the close of each chapter.

Throughout the book runs the thread of good public health practices—with emphasis on prevention. Even if a public health nurse does not teach Red Cross classes, this new edition of a favorite textbook will be useful to her in her community health education work.

ELIZABETH R. FERGUSON

*Baltimore, Maryland*

## THE AMERICAN JOURNAL OF NURSING FOR OCTOBER

Meningitis.....	Russell A. Nelson, M.D.
The Indian Service in Alaska.....	Bertha M. Tiber, R.N.
Locating "Hidden Nurses".....	Mary C. Walker, R.N.
Our Not-so-young Married Nurses.....	
Lead Poisoning.....	Paul Reznikoff, M.D.
This War—The Business of Every One of Us.....	Gertrude S. Banfield, R.N.
An Experiment in Day Care.....	Vernice M. Swenson, R.N.
How a Bill Becomes a Law!	
Practical Cover for Wet Dressings.....	Wilkins R. Manning, M.D., and Elizabeth H. Farmer, R.N.
Transurethral Prostatic Resection—Nursing Care.....	Henry A. Buchtel, M.D., and John R. Pace, R.N.
England—June 1942.....	Virginia M. Dunbar, R.N.
Hospital Personnel Health Service.....	Irma Biehuse, R.N.
One Word More About Married Student Nurses.....	Edith H. Smith, R.N.
Introducing Anatomy and Physiology.....	Mildred Reed, R.N.
Teaching Diabetic Patients.....	Margaret E. Newman, R.N., and M. Ruth Smith, R.N.
Prophylaxis Against Tetanus.....	Ralph Spaeth, M.D.
A Front Line Nurse with the Free French.....	Nurse Jose Pearce
Planning for Civilian Casualties.....	
Mother Prepares to Take Over.....	Margaret C. Foley
Nursing Care in Spinal Fusion.....	Sister Vincent of the Eucharist, R.N.
A Historian Speaks.....	Alice W. Spieske
Guidance Aspects of a College Health Service.....	Mary C. Houston, R.N.

### What Progress?

(Continued from page 539)

specific suggestions for training and salary of such workers. The whole question was referred to a joint conference called by the government's Subcommittee on Nursing and the National Nursing Council in Washington, D.C., on September 21. At this conference, plans were made to take immediate steps for training and using greatly increased numbers of auxiliary workers in civilian hospitals and other community agencies. Wide-spread use of these workers in England in both military and civilian services was described by Elisabeth C. Phillips, just returned with the American Red Cross-Harvard Field Hospital Unit, who gave some sidelights on what England has learned in three years of war.

The urgent need for acceleration of the nursing education period to meet unprecedented demands was discussed, and the recommendations of a special committee for compressing the basic course into shorter time were referred to the Subcommittee on Nursing. The National League of Nursing Education has recommended a plan for adjusting the basic curriculum, which will shorten the period of preparation for nursing. (The plan is published in *The American Journal of Nursing* for October, page 1182.) Grants of federal funds have been made to 213 schools of nursing in 41 states and Puerto Rico for the fiscal year 1942-1943. A goal of at least 55,000 new students has been set for the end of the government fiscal year, June 30, 1943. This will provide an increase over last year of 10,000 students.

Results to date in national planning for nursing were reviewed in reports of federal and national agencies concerned with nursing in the war. Briefly, progress is being made in building the

reserve for the military services, but little progress has been made for the country as a whole on the civilian front. The rate of enrollment in the Red Cross First Reserve has increased in the last two months, probably stimulated by priority of nursing on the radio networks, and other publicity; closer working relationship between the Council and the Red Cross to the extent of sharing personnel (page 598); and appointment of paid Red Cross workers to 40 key cities where the largest numbers of nurses are to be found.

Effective supply and distribution of nursing service for civilians, however, await the completion and activation of co-ordinated local organization, which is far from being achieved. Piecemeal organization, with different groups acting independently on different activities, will not achieve the community planning that is necessary to meet our grave responsibilities. A plan for a post-card survey of the country's nurse power has been made by the Inventory Committee of the Subcommittee on Nursing. The survey will be carried out by the U. S. Public Health Service working through the special agencies which secured the original inventory material. Planning by national groups is going forward and additional tools are being prepared for guidance of state and local groups—for nursing in general, nursing education, and public health nursing in particular. Basic to implementation of any overall plan, however, is a strong local nursing council for war service in every community. Help in organizing these councils may be secured through the state nursing council for war service, which in turn is assisted by the National Nursing Council for War Service. The first step in each community is to build such an organization now.

P.P.

# NEWS

## NEWS FROM THE COUNCIL

**N**EW OFFICERS of the National Nursing Council for War Service, elected at its July 22 meeting, are:

Stella Goostray, Boston—chairman  
Sophie C. Nelson, Boston—vice-chairman  
Marion W. Sheahan, Albany—secretary  
Edward Robinson, New York—treasurer  
Henry B. Stimson, New York—assistant treasurer

The Council was incorporated under the corporation law of the state of New York on July 28, 1942. It now has 24 voting members, representing the following organizations:

American Nurses' Association  
National League of Nursing Education  
National Organization for Public Health Nursing  
National Association of Colored Graduate Nurses  
Association of Collegiate Schools of Nursing  
American Red Cross Nursing Service  
Subcommittee on Nursing of Health and Medical Committee, Office of Defense Health and Welfare Services

The chairmen of the Council's Committee on Recruitment of Student Nurses and Committee on Supply and Distribution are also members, together with the chairman of the Joint Committee on Community Nursing Service.

Ex-officio members include representatives from the Office of Civilian Defense, the federal nursing services, and the Canadian Nurses' Association; the executive officers of the national nursing organizations including the Nursing Information Bureau; editors of *PUBLIC HEALTH NURSING* and *The American Journal of Nursing*; and the staff of the Council.

The Board of Directors consists of 17 voting members—the 5 corporation officers and 12 other voting members:

Julia C. Stimson, Susan C. Francis, Nellie X. Hawkinson, Lucile Petry, Marion G. Howell, Mrs. Frederick S. Dellenbaugh, Jr., Mrs. Marion B. Seymour, Mrs. Mabel K. Staupers (alternate), Sister M. Olivia Gowan, Isabel M. Stewart (alternate), Mary Beard, Virginia Dunbar (alternate), Alma C. Haupt, Katharine Faville, Katharine Tucker.

The staff of the Council is comprised of: Elmira B. Wickenden, director; Florence M. Seder, public relations secretary and secretary of the Committee on Recruitment of Student Nurses; Josephine Nelson, assistant public relations secretary; Susan C. Francis, part-time (volunteer) consultant in Clearing Bureau; Margaret S. Taylor, guidance secretary, Clearing Bureau; Barbara Perkins, assistant guidance secretary, Clearing Bureau; Dorothy W. Conrad, secretary of Supply and Distribution Committee.

Miss Francis, who is well known throughout the country as director of the Philadelphia Children's Hospital School of Nursing and former president of the American Nurses' Association, is giving volunteer time to the Council three and one half days a week. She is assisting with clearance and guidance activities, and serving temporarily as assistant director to succeed Katharine E. Peirce, who has returned to the John Hancock Mutual Life Insurance Company after a loan of her services by the Company for three months.

Mrs. Conrad has been lent part time to the American Red Cross since July 15 to work on enrollment in order to coordinate more effectively the work of the Council and the Red Cross in this activity. She spends part of each week at Red Cross Headquarters in Washington, D.C.



## MERIT SYSTEM STUDY

A MERIT SYSTEM Study was initiated by the American Public Health Association in July 1941 at the request of the U. S. Children's Bureau and the U. S. Public Health Service. Broadly speaking, the study is concerned with the personnel problems arising from the application of civil service or merit systems to professional workers in the field of public health. At present, however, attention is being concentrated upon the examining or selective process itself, and examinations in the field of public health nursing are the first to be studied. At the request of merit system supervisors or civil service officials the Association will supply valid and efficient examination materials to meet with the approval of professional health workers. The staff of the study will, on request and insofar as feasible, give consultative service to merit system agencies on examinations from the point of view both of the professional subject matter and of examining methods. It is hoped that investigations can be made to the end that future competitive examinations may be improved.

The study is under the immediate direction of the Committee on Professional Education of the A.P.H.A. The members of the Committee include: George H. Ramsey, M.D., chairman; Reginald M. Atwater, M.D., Martha L. Clifford, M.D., Dorothy Deming, R.N., Alfred H. Fletcher, Clarence L. Scamman, M.D., and Herman G. Weiskotten, M.D. Miss Deming is now a member of the staff, and Hortense Hilbert has been appointed as representative of the public health nursing field. The National Organization for Public Health Nursing is co-operating closely with the study by giving consultation from the point of view of public health nursing as a profession.

• Ida MacDonald has been appointed associate director of Red Cross Volunteer

Nurse's Aide Service to succeed Mrs. Elsbeth E. Vaughan, who has been in charge of this Service. Miss MacDonald has been assistant professor in nursing education at the University of Minnesota School of Nursing. She has had broad experience in the field of supervision and teaching. Mrs. Vaughan will continue her work as assistant director of the Red Cross Nursing Service in public health nursing.

• An eye health conference will be held in St. Louis, Mo., under the auspices of the National Society for the Prevention of Blindness on October 25 and 26, in conjunction with the 1942 meeting of the American Public Health Association. Topics to be discussed include eye problems of the young child, education of the partially seeing child, recent advances in the treatment of trachoma, public health nursing in trachoma control, school lighting, screening procedures for vision testing and follow-up, and a talking slide film on industrial eye safety, "The Eyes Have It." Speakers will include ophthalmologists, a supervisor of sight-saving classes, a state public health nursing supervisor, a lighting engineer, and the National Society's associate for nursing activities, Eleanor W. Mumford, who will be in charge of the conference.

Registration is open to physicians, public health nurses, and health educators registered for the A.P.H.A. meeting. Attendance will be limited to 60. Advance registration is required. Applications should be made to the National Society for the Prevention of Blindness, 1790 Broadway, New York, N. Y., before October 5.

• A meeting of the officers of the American Association of Industrial Nurses was held in New York, N. Y., on August 15 to draft a tentative form for the constitution and by-laws and to make plans for the Association. Officers present

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were: Catherine R. Dempsey, president; Elizabeth Sennewald, 1st vice-president; Polly Acton, 2nd vice-president; Marion G. Dowling, corresponding secretary; Mrs. Marion C. Brittingham, recording secretary.

Joint conferences have been held annually since 1938 by the New England, New York, Philadelphia, and New Jersey organizations, and early in 1941 the Detroit Industrial Nurses' Club joined the group. Plans have been made for the first annual meeting of the American Association of Industrial Nurses, to be held in New York, N. Y., May 1-2, 1943.

- The second annual institute on tuberculosis for Negro nurses will be held at the Homer Phillips Hospital in St. Louis, Mo. The tentative dates are October 21-23. The institute, which is sponsored by the Tuberculosis and Health Society of St. Louis in co-operation with the National Tuberculosis Association, will be conducted by Fannie Eshleman,

supervisor of nurses at The Henry Phipps Institute in Philadelphia. Emphasis will be placed upon the wartime challenge to nursing of the prevention and control of tuberculosis.

- The Delaware Merit System Council announces merit examinations for the following classes of positions in the Delaware State Board of Health, with yearly salary ranges indicated:

Director of Public Health Nursing—\$2700 to \$3300; Public Health Nursing Supervisor and Consultant Nurse in Special Fields—\$1800 to \$2250; Public Health Nurse—\$1500 to \$1920; Junior Public Health Nurse—\$1260 to \$1500.

Further details and application blanks may be secured from Charles W. Bush, merit system supervisor, P. O. Box 1911, Wilmington. Closing date for filing applications is October 10.

- The Indiana State Personnel Division announces an examination for the position of Orthopedic Nursing Consultant I (women only), with a salary range of \$150 to \$200 a month. Applications may be filed until further notice. Forms may be obtained from the State Personnel Division, 141 South Meridian Street, Indianapolis.

(Continued on page 19)

# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## Where Has it Been Done?

**N**O ONE WHO attended the Biennial Convention in Chicago last May could have left without a feeling of urgency about the necessity of tightening our public health nursing "belts." Many specific recommendations as to where and how to pull up were made and some, notably that nonprofessional activities be delegated to volunteers or paid clerical and housekeeping personnel, have been put to work already.

Progress has been made in sifting services, families, and patients to find those which should be considered priorities because of the seriousness of their health problems. At the request of the N.O.P.H.N., groups of public health nurses in various parts of the country are now at work setting up broad guides for this screening process. PUBLIC HEALTH NURSING will report on these from issue to issue. We hope local groups everywhere will adopt and enlarge these suggestions quickly. Many agencies have already made a start. They have set up special channels for planning in which every staff nurse participates. Indeed, the opportunity is welcomed by these younger members of our profession, among whom are products of our best educational institutions, with fresh viewpoints of import to us all.

But the difficult recommendation—that agencies study and coordinate community services with a view to elimination of duplications—remains to be heard from. Maybe we have not allowed sufficient time for the study aspect of this task. Maybe those who have adopted a plan are hesitating to tell about it until they see if it works. At

any rate, almost no reports of bold, major community reorganization have come to light.

This is a ringing challenge to public health nursing agencies, particularly east of the Mississippi and north of the Mason-Dixon Line. This is a privileged area in point of view of number of prepared public health nurses, as well as institutions for preparing them. Every agency in the area has a moral obligation to cast its professional eye on areas less well supplied with professional personnel, among which are the new industrial and extra-cantonment areas in all parts of the country. In many such areas the influx of population has resulted in an almost overwhelming upthrust of primary health problems. To provide adequately for such necessities as sanitation, communicable disease control, maternal and child care, adjustment of disrupted family life requires the utmost of wisdom, experience, and skill. In short, these areas should command our most mature workers. If we honestly face the situation, there can be no argument that consolidation of forces in the privileged areas should be done, experienced workers shared with less privileged areas.

These are difficult challenges. Intense, long-continued interest in a single nursing agency program is not easily shifted to equal devotion to community-wide planning. It usually involves change in the attitude and sometimes the personnel of both the lay committee or board and the nurse administrative group.

*(Continued on page 649)*

# Maternity Leaves in Public Health Nursing Agencies

By HORTENSE HILBERT, R.N.

**T**HE PAST decade has seen some liberalization of personnel policies concerning the employment of public health nurses who are married. Actual practice in regard to the granting of maternity leave and the employment of married women varies considerably among agencies employing public health nurses. Those that have hitherto refused employment to married nurses now find themselves in the position of having to accept them because the Army and Navy are taking away large numbers of nurses who are eligible for military service only if unmarried and under 40 years of age.

Because of the increase in employment of married nurses by public health nursing agencies, questions in regard to maternity leave arise more frequently than usual. By way of an answer to some of these questions that come to the National Organization for Public Health Nursing, information has been collected from such sources as the U. S. Women's Bureau and federal, state, and municipal civil service groups, and from the public health nursing agencies included in the N.O.P.H.N. 1942 yearly review of public health nursing. Nursing agencies answering two specific questions in the 1942 schedule gave points of view in respect to the time of discontinuance of home visiting by the nurse who is pregnant, and also indicated under what conditions these agencies would change previous policies about her work. Public health nursing associations, departments of health and education, and some agencies representing combinations

of these were included in the Yearly Review.

Information about general provisions for granting leave of absence before and after childbirth was obtained from the Women's Bureau of the U. S. Department of Labor:

## LAWS GOVERNING EMPLOYMENT

In 1940, five states (Connecticut, Massachusetts, Missouri, New York, and Vermont) had laws governing employment before and after childbirth, and in one additional state (Washington) an order had been issued by the Industrial Welfare Committee which had the same effect as law. In these states leave of absence for maternity applied to women in private employment and ranged in time from 4 to 23 weeks which was, with one exception, divided between the antepartum and the postpartum periods. In these six states workers in such establishments as factories, mercantile establishments, mill workshops, mechanical establishments, laundries, bakeries, restaurants, places of amusement, canneries, dry cleaning works are included.

A study published in 1939 by the International Labor Organization, "The Law and Women's Work," (Chapter III) includes a comprehensive discussion of laws relating to the employment of women before and after childbirth, which shows that some other countries are in advance of the United States, having legal provisions for maternity leave without loss of job and for more or less substantial benefits extending over a definite period.

#### U. S. GOVERNMENT REGULATIONS

Regulations governing leaves of absence among employees of the United States Government, in an amendment of March 1940,\* provide that:

Sick leave with pay shall be granted to employees when they are incapacitated for the performance of their duties by sickness, injury, or pregnancy and confinement . . .

Payment can be made only for the time allowed the individual for annual and sick leave. There are no special provisions for maternity leave. However, it has been customary in some bureaus of the Federal Government to grant furloughs of various lengths, depending upon individual requirements.

#### STATE CIVIL SERVICE SYSTEMS

Provisions for maternity leave of women employed under state civil service systems were as follows, according to a questionnaire study made in 1937 by the U. S. Women's Bureau of states that then had civil service laws:

Maternity leave without pay was allowed state civil service employees in New York and New Jersey. In California, Colorado, and Wisconsin leave was granted but whether with or without pay was not stated. In Illinois, Massachusetts, and Ohio the appointing officer or department head was given responsibility for determining the policy in regard to maternity leave. In Maryland it was required that a woman take at least a year's leave of absence for maternity, and the position was immediately filled by a permanent employee. Although she might remain on the civil service register and at the end of the year apply to have her name placed on the employment list, this virtually amounted to dismissal. No information has as yet been assembled in regard to

provisions for maternity leave in states that have since 1937 introduced civil service systems.

In answer to a recent inquiry by the N.O.P.H.N., the New York State Department of Civil Service stated:

There is no definite policy or practice relating to maternity leave in state departments. It is the general practice to grant whatever leave the confined person usually desires up to one year, and in most cases it has been requested that not less than six months be taken.\*\*

One of the New York State departments, the Department of Labor, makes the following provisions for maternity leave:

Maternity leaves are granted without pay and are approved on the basis of six months or less, with extension beyond the six months if desired and approved, but not beyond one year. A doctor's certificate must accompany the request. Employees, however, may use any accumulated vacation, accumulated overtime and up to three-quarters of whatever accumulated sick leave they have to their credit . . . , before the maternity leave is effective. The total absence, however, including leave with pay is not to exceed one year.\*\*\*

#### A CITY CIVIL SERVICE COMMISSION

The following sections of the staff regulations of the Municipal Civil Service Commission of the City of New York apply to leave of absence for maternity:

a. An employee who is pregnant shall report the condition to her bureau head and to the office of the Secretary at least five months before confinement, presenting a physician's diagnosis and giving the approximate date of confinement. Arrangements will be made to keep such requests anonymous if desired by the employee.

b. Maternity leave shall be taken for a period of four months prior to confinement and three months after confinement. If an employee desires to extend maternity leave, she may request additional time before or

\*Annual and Sick Leave Laws and Regulations for Government Employees. May 1, 1940, p. 7. Superintendent of Documents, Washington, D.C.

\*\*Letter from J. A. Kretchmer, administrative supervisor, New York State Department of Civil Service, June 11, 1942.

\*\*\*Employees' Handbook, p. 12. New York State Department of Labor.



after confinement. The diminution of the maternity leave by one month prior to or subsequent to confinement, or both, will be considered upon proper medical evidence. The recommendation of the Chief Medical Examiner of the Commission will be conclusive in these cases.

c. Overtime, unused sick leave and vacation credit may be granted as compensated leave in conjunction with maternity leave. All accrued overtime may be credited. Sick leave and vacation time accrued up to the start of the maternity leave may also be added to the time to be taken as compensated leave.

d. Permanent per annum or per monthly employees only shall be entitled to the benefits of this maternity leave policy.

e. In the case of stillbirths or other abnormal medical conditions resulting from pregnancy, employees shall obtain from the Chief Medical Examiner of the Commission written permission to return to work, which shall be presented at the office of the Secretary upon return.

#### 1942 YEARLY REVIEW

In addition to the foregoing examples of legal provisions that govern maternity leave for workers in certain types of private employment, and for employees under certain civil service systems, the N.O.P.H.N., as was previously mentioned, has through its 1942 Yearly Review of public health nursing gleaned some information relating to policies in respect to leave of absence for maternity in 532 agencies that employ public health nurses. Represented in this group are 201 public health nursing associations, 177 departments of health, 140 departments of education, and 14 combination agencies. Of all the 532 agencies, only 36 say that they will not employ married nurses. Of the 36, more public health nursing associations than either departments of health or departments of education will not employ married nurses, and more departments of education than departments of health.

Responses to the question, "In what month of pregnancy does the agency expect the nurse who is pregnant to discontinue home visiting?"—which was incorporated in the schedule for the

1942 Yearly Review—showed that 116, or about one fifth of the total 532 agencies, have a policy in respect to discontinuance of home visiting. In many instances the policy is quite flexible.

Of the 116 agencies having a policy, 64, or more than one half, expect the public health nurse to discontinue home visiting during the second trimester; 19 expect her to stop during the first trimester; and only one indicated a period later than the sixth month. Nine agencies expect the nurse to discontinue home visiting as soon as her pregnancy is known, and 23 base their decision upon individual circumstances, such as her economic situation, the advice of her physician, or her appearance.

It would naturally be expected that public health nursing agencies which stand so definitely for health protection and promotion in the communities they serve would make extraordinarily good provisions for the maternal health of their own personnel. It would be interesting to know whether the policies reported are primarily the result of the agencies' concern with the welfare of the employee or whether they have been largely influenced by agency interests and even taboos.

As to the second question on policies regulating maternity leave, "Under what conditions would the agency change its policies in regard to the work of the pregnant nurse?"—answers indicated that many agencies were sufficiently flexible in policy to consider modifications of their general rule.

For instance, six agencies of the 19 having a policy of discontinuance of home visiting during the first trimester stated that modification would be considered. In one instance this is upon the written request of the nurse; in two, if the health condition of the nurse warrants it; in another, it depends upon the physical condition of the nurse and the needs of the agency. In one, discontinuance of service may be deferred

until the second trimester if the war has affected the needs of the agency for personnel; and in another, if the physician permits it.

Of the 64 agencies that expect the nurse to discontinue home visiting during the second trimester of pregnancy, 28 will consider modifications of this policy. Eight will take into account a combination of individual circumstances; nine specify physical condition and physician's approval; and one, the economic need of the individual nurse. Six agencies indicate that the appearance of the nurse would influence their decision, and two state that the kind of district in which she works and the attitude of the people to her pregnancy would be the determining factor in considering modification of their rule. Two agencies, both official, say that the scarcity of nurses for public health nursing positions will have a bearing on changes in policy in regard to discontinuance of work during the second trimester of pregnancy, individual health conditions permitting.

The third trimester of pregnancy is indicated by only one agency as the time that it expects nurses who are pregnant to stop home visiting. This agency states that this policy will be modified according to the physical condition of the individual and her ability to carry on her work.

Of the 185 agencies with no definite policy at present, 10 commented upon their practices in regard to discontinuance of service by nurses who are pregnant. Two departments of education reported that the policies adopted for teachers, their work being discontinued during the fourth and fifth months of pregnancy respectively, do not apply to nurses. By two other agencies, one a health department and the other a public health nursing association, 7 months and 4 months are designated as the periods in pregnancy when the nurse is expected to discontinue home

visiting. One department of health reported that it is awaiting a regulation from the municipal department of personnel and in another the health officer, it is said, may at his discretion continue salary for 3 months in case of maternity or illness.

One other city department of health states unequivocally that it does not wish to grant leave of absence because of pregnancy, although it could. Usually this agency expects home visiting by the nurse to discontinue after the third month of pregnancy. Another department of health has only this year begun to employ married nurses and has not yet defined a policy in respect to maternity leave. One combination agency stated that all provisions for maternity leave are decided upon an individual basis.

Thus, from the data secured from 532 public health nursing agencies in the N.O.P.H.N. 1942 Yearly Review, it would appear that a slightly higher proportion of voluntary public health nursing agencies have adopted policies in regard to the period in pregnancy at which nurses are expected to discontinue home visiting than any other single type of official or combination agency. However, the proportion of departments of health is very similar to that of public health associations. The fact that public health nursing associations are more likely to include nursing care of the sick in their services—a type of work that involves lifting and other strenuous physical activity in addition to the stair climbing and automobile driving that are so much a part of the work of all public health nurses—may account for the fact that definite provisions for maternity leave are more extensively made by them.

Among the 116 agencies that have adopted policies relating to maternity leave the majority opinion seems to be that the second trimester of pregnancy is the most appropriate time for discon-

tinuance of home visiting by nurses who are pregnant. Whether it is customary to make arrangements for the nurse to continue in other types of work, such as assisting in clinics or conferences, or group education and office conferences, is not known from the information at hand. However, the fact that the health condition and other individual circumstances of the public health nurse are so often reported as being taken into consideration, both in the agencies having a general policy in regard to maternity leave and those not having such a policy, would indicate that adjustments in her work are probably made if possible.

#### NEW STANDARDS OUTLINED

The Children's Bureau and the Women's Bureau of the U. S. Department of Labor have recently issued recommendations\* relating to employment policies and care for pregnant women employed in industry in which special provisions for their care are emphasized. Some of these are applicable to pregnant women in other types of work as well. For instance, the following recommendations seem particularly pertinent to the public health nurse who gives a bedside care service:

"Pregnant women should not be employed more than eight hours a day nor more than 48 hours a week and it is desirable that their hours of work be limited to not more than 40 hours per week.

"Every woman, especially a pregnant woman, should have at least two 10-minute rest periods during her work shift, for which adequate facilities for resting and an opportunity for securing nourishing food should be provided.

"It is not considered desirable for

pregnant women to be employed in the following types of occupation, and they should, if possible, be transferred to lighter and more sedentary work: (a) occupations that involve heavy lifting or other heavy work (b) occupations involving continuous standing and moving about."

In regard to maternity leave it is stated that "a minimum of six weeks' leave *before* delivery should be granted, on presentation of a medical certificate of the expected date of confinement." And, "At any time during pregnancy a woman should be granted a reasonable amount of additional leave on presentation of a certificate from the attending physician to the effect that complications of pregnancy have made continuing employment prejudicial to her health or to the health of the child."

After delivery at least two months' leave of absence is recommended with the proviso that additional leave beyond two months be granted, in case of complications of delivery or of the postpartum period, upon presentation of a certificate to this effect from the attending physician.

#### OBSTETRICAL OPINION

As a further guide to public health nursing agencies who may for the first time be considering policies or may be reviewing former policies in regard to the employment of married women and also maternity leave for public health nurses on their staffs, opinions were sought from several leading obstetricians in various parts of the country.

According to the view expressed by a midwestern obstetrician and teacher, a six months' leave of absence for child bearing is adequate. This could well include four months before the estimated date of confinement, and two months after delivery. He expresses skepticism over the necessity of a nine months' leave, and also expresses the belief it is possible the six months' leave might be

\*Children's Bureau and Women's Bureau. Standards for Maternity Care and Employment of Mothers in Industry. U. S. Department of Labor, Washington, D.C. 4 pp.

shortened without harmful effects to mother or child.

Another obstetrician, also from a central state, writes that he knows of no authoritative literature on the subject, but that he will give his personal opinions "which are frequently modified to meet the necessities of the patient." He believes that nurses should not work at their profession during the last trimester, and for at least six weeks postpartum. He points out that it is ill-advised for women who are pregnant to expose themselves to contagious or infectious diseases, and that it is advisable for the nurse who is pregnant to avoid caring for patients with such diseases. Because pregnant women are subject to dizziness and fainting and also because of the possibility of injury due to accidents, he believes it inadvisable for them to drive cars.

An obstetrician from a large city in the northeast believes that if a public health nurse continues to work she should cut down stair climbing and difficult bedside care services as much as possible. Also, she should avoid doing hard nursing work at what would be her menstrual period if she were not pregnant. In any case, he believes that the nurse should stop work at the seventh month, and at once if there are any complications of pregnancy. He points out, too, that since every woman varies in each pregnancy, it is difficult to lay down definite rules. He suggests in order to absolve the employing agency from any legal responsibility, should the woman who is pregnant miscarry while employed, that at the time of their employment all married nurses should be required to sign agreements to notify the employer if and when they become pregnant.

A fourth obstetrician begins his letter with the statement, "It is not a simple matter to make an adequate reply, especially if one has somewhat radical views as to the responsibility of women

towards pregnancy." He goes on to say:

The question as to whether public health agencies should employ married women in nursing capacities is one that must be judged individually. However, there is a limit, it seems to me, for active nursing duties by a pregnant woman, if she is to fulfill her obligations to the patient or the employing agency. Some pregnant women could do easy work in the earlier months depending upon their symptoms, but I question their capability after the sixth month, especially as this involves long hours, visitations, and auto driving. In addition there are evident psychologic factors which enter into the situation.

My own feeling is that when a woman is pregnant, she has a paramount job on her hands, and household cares usually are a sufficient task. In this connection, it must be admitted that today many women are not involved in the latter.

As for maternity leave for regularly employed nurses, this depends on circumstances. Among teachers, a period of from 15 to 18 months is considered reasonable in a normal pregnancy, with a reduction in cases of miscarriage, ectopics, etc. Most teachers, however, seem to be in a position to provide care for their babies when they return to work.

This particular obstetrician then raises the point as to whether public health nurses are economically in a similar position.

He also states his belief that the pregnant nurse cannot stand the strain of work after the sixth month, and preferably should stop even sooner. He concludes that maternity leaves are also determined by the value of the nurse to the agency, pointing out that, "If she bears a child and must provide for it, her interests necessarily are divided and this may interfere in her giving full attention to her obligations as a nurse. It would be preferable not to employ married women unless pregnancy can be ruled out."

There seems to be general agreement that a reasonable policy concerning maternity leave is one that provides for discontinuance of work during the second trimester of pregnancy and for at least two months after delivery. Such a policy

needs to be flexible, taking into account physical condition and other individual circumstances.

Public health nurses who drive automobiles, climb stairs, and give nursing care which involves lifting and other heavy physical exertion, need to modify their activities when they become pregnant, or discontinue them altogether.

On the other hand, there is now urgent

need to have every nurse in active service. There is also the point that each nurse wants to make her individual contribution to her utmost capacity. Public health nursing agencies, therefore, will wish to consider wisely individual needs, and make every possible adjustment to allow the nurse who is pregnant to continue in her work under conditions that are not detrimental.

## NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

### PLACEMENTS

- \*F. Eleanor Strause, venereal disease consultant, Illinois State Department of Public Health, Springfield, Ill.
- Mabel L. Nodwell, director, Visiting Nurse Association, Sioux City, Iowa.
- \*Kathleen A. Norris, director, Public Health Nursing Association, Cedar Rapids, Iowa.
- \*Lilian S. Henderson, director, Visiting Nurse Association, Dubuque, Iowa.
- \*Edell F. Little, director-supervisor, Charleston Public Health Nursing Association, Charleston, W. Va.
- \*Nancy J. Cummings, nursing field consultant, American Red Cross, Midwestern Area, St. Louis, Mo.
- \*Mrs. Bernice G. Gardner, nursing field consultant, American Red Cross, Midwestern Area, St. Louis, Mo.
- \*Winifred Imogene Patterson, instructor in tuberculosis nursing, University of Michigan, School of Public Health Nursing, Ann Arbor, Mich.
- \*Mrs. Elizabeth Smith Newton, director of health and welfare service, Cook County School of Nursing, Chicago, Ill.
- Helen F. Turner, director of negro health service, Bergen County Tuberculosis and Health Association, Hackensack, N. J.

\*Romaine M. Smith, supervisor, State of Colorado, Division of Public Health, Denver, Colo.

\*Ila Z. Moore, supervisor, City Department of Health, Peoria, Ill.

\*Eileen C. Dixon, student supervisor, Community Health Service, Grand Rapids, Mich.

Celia Anita Smith, home nursing instructor, American Red Cross, Home Nursing Service, Cleveland, Ohio.

Elizabeth C. Smith, public health supervisor o.p.d., Pennsylvania Hospital, Philadelphia, Pa.

\*I. Anna Jontz, college nurse, State Teachers College, Superior, Wis.

Mrs. Mabel B. Zickefoose, school nurse, Le Mars Public Schools, Le Mars, Iowa.

Mrs. Bernyce Mae Finkel, industrial nurse, Foote Brothers Gear & Machine Corporation, Chicago, Ill.

Rita Jane Franke, industrial nurse, United Wall Paper Company, Chicago, Ill.

Mari Caroline Goebel, industrial health advisor, Republic Drill & Tool Company, Chicago, Ill.

Juanita Cecilia Johnson, industrial nurse, Foote Brothers Gear & Machine Corporation, Chicago, Ill.

Mrs. Rosayls Messner, industrial nurse, Foote Brothers Gear & Machine Corporation, Chicago, Ill.

Elsie Yetta Pearlman, industrial nurse, Grand Sheet Metal Works, Chicago, Ill.

Mary M. Sommers, industrial nurse, Foote Brothers Gear & Machine Company, Chicago, Ill.

Suzanne B. Taber, industrial nurse, Hammond Instrument Company, Chicago, Ill.

(Continued on page 656)

\*The N.O.P.H.N. files show that this nurse is a 1942 member.



# British Women in the War Services

By ELISABETH C. PHILLIPS, R.N.

**T**HROUGHOUT their history the people of the British Isles have held a most conservative viewpoint as to the place of women in business and industrial life, but now the menace of totalitarian warfare has swept away, and is continuing to sweep many, of their traditional ideas. Definitions of woman's role are being modified drastically. To try to define the difference between combatant and noncombatant services as seen in the British Isles today is well nigh impossible—when incendiary and high explosive bombs rain down on homes, schools, and factories, even little children become combatants.

The people of Great Britain now believe that it is ridiculous that able-bodied women be denied the privilege of doing vitally important work in the all-out war effort. A gradual assumption by women of more and more of the work heretofore performed by men in industry and in the fighting forces is seen everywhere throughout the country.

The registration and conscription of women was welcomed by the vast majority of them. They have been quick to recognize that World War I got for them the acknowledgment by men of their right to equal privileges in the state. Women now realize that this war demands the acknowledgment by them of the equal obligations they, by the same token, owe to the state. Women are daily proving themselves equal to the task laid before them by the fighting men whom they replace in the shop, the store, the factory, on the farm, in manning anti-aircraft barrage balloons and guns, in decoding messages and in operating the hundreds of radio-location stations that determine the presence of

enemy planes. The line of distinction between war work and work done under war conditions is very narrow. Both are part of the "war effort" of the country. Both are therefore blood and sinew of a country at war.

There are three women's organizations attached directly to the navy, army, and air force. Women in these groups receive pay but it is still less than that paid to men for similar service.

1. The Women's Royal Naval Service, familiarly known as the "Wrens," was also active during the last war but was demobilized in 1919. Many of its original members enrolled again when the service was reformed in April 1939. Like the Royal Navy, whose traditions and terminology they follow so closely, they draw a high proportion of both officers and ratings from families with a naval heritage. The W.R.N.S. is the smallest (and the most select) of the three women's services, but their number is being increased by about 800 a month in order to meet the demands of the naval authorities. At present there are about 26,000 "Wrens" in the service. W.R.N.S. units are attached to every Naval Shore Establishment in the United Kingdom. There are two main training depots in London and smaller ones in most of the home ports. In these stations the recruit receives a fortnight's preliminary training during which time she is on probation. After this period, accepted volunteers then sign on for the duration and agree to obey orders and go wherever they are sent. They receive further training in the special duties which they will perform. Such work is ashore or in harbor but in every instance frees a man to

serve at sea. Their duties may be of the household type or clerical, or they may concern the plotting of operations, or the intricate and important job of folding parachutes for the Fleet Air Arm. (A pilot's parachute is folded differently than is an air gunner's, the difference depending on the means of exit by which he is likely to leave the plane.) "Wrens" may also be engaged in the work connected with naval communications—a most confidential job in which they do coding, decoding, and signaling, and carry on allied activities.

With the possible exception of a few women with highly specialized qualifications, all the officers are recruited from the ranks of the W.R.N.S. After appointment they receive two weeks of officer's training in the historical Royal Naval College in Greenwich.

2. The Auxiliary Territorial Service is the largest of the three women's services attached to the fighting forces. It has over 200,000 members who are essentially part of the army. A school of instruction for officers was set up in the autumn of 1938. Recruits for the ranks have poured in faster than quarters, equipment, or instructors could be provided. These women must be between the ages of 18 and 43 and sufficiently fit to give service in the branch they have chosen, the standard varying considerably with the type of work the individual recruit will do. All effort is made to place each recruit in the form of work for which she expresses preference at the time she is enrolled, providing she is fitted for it both mentally and physically.

The recruit is first sent to a training center for two months during which time an estimation of her capabilities is made. There she is equipped, drilled, given physical training and lecture courses and in effect made an acceptable "soldier." If her civilian training and experience have prepared her for the work chosen (cook, clerk, orderly, housekeeper, and

the like), she is posted directly to a working unit, but if she has selected specialized duty she then begins a training course which will prepare her for it. Perhaps this means that she will need a course in the handling and upkeep of army vehicles—lorries and trucks of all sizes, ambulances, and sedans. She must learn to drive in convoy with a minimum of light under blackout conditions and she will be taught how to repair speedily even the complicated motor of a three-ton lorry. Perhaps she will go to an A.T.S. Signal School whose graduates are skilled teleprinters and telephonists, or to an A.A. Training Regiment to learn to direct and control the fire of the anti-aircraft guns. But from the moment these women begin their training they work as a battery and learn their duties with the same men with whom they will ultimately serve. An "At" who holds a scientific degree is taken out of the ranks and sent to the Army School of Experiments where she engages in research in the physics of gunnery.

3. Women's Auxiliary Air Force. This service was formed in June 1939, when it was shown that the duties required of women working with the R.A.F. would differ materially from those with the army. Like the other women's services, the main object of the W.A.A.F. is the replacement of men by women in certain noncombatant posts. The recruits are chosen as far as possible from the women whose civilian occupations have fitted them for the work they will do in the W.A.A.F., although additional training is provided in specialized fields. "Waaf's" do not fly but they are liable for service in any part of the United Kingdom or overseas. Recruits must be between 17½ and 43 years old. On enrollment they have a fortnight's disciplinary training. When the W.A.A.F. was established there were five ground trades open to its members; now there are about 50. Many of them

offer good training for peacetime professions. The photographic section is one of these. There are opportunities for women of intelligence and with a mechanical bent to assume jobs in which they inspect, maintain, test for correct operation, and repair scientific instruments both large and small. Women electricians fill a great need in caring for the wiring, starters, generators, motors, and accelerators of airplanes. Women flight mechanics undertake the responsibility of inspection and maintenance of the body work and undercarriage of planes, while others look after and test all kinds of engines. Women armourers are charged with the work of installing and maintaining machine guns, cannons, camera guns as well as the care and handling of ammunition. In short, the safety of the R.A.F. is dependent on its women members.

Radio-location, "the best kept secret of the war," is entrusted to women. By means of electric rays this apparatus registers the presence of any aircraft in a locality and notification is made immediately by the operators of the radio-locaters to the operation rooms of the R.A.F. where the location of the planes is plotted on large table maps. Radio operators and plotters are women more often than not and they work side by side with the men of the R.A.F. under conditions of great strain and danger.

The importance of correct diet is stressed everywhere throughout the R.A.F. which is known as "the best fed service." The "Waaf's" who do the cooking have a very special training. They are responsible not only for the cooking of meals served to the air crews on the ground but for the packing of the haversacks which the crews take with them on patrol or on long bombing raids. The W.A.A.F. cooks are also taught to do invalid cookery.

Women who in civilian life were tailoresses, upholsterers, or seamstresses are most welcome recruits to the W.A.A.F. for they are sorely needed in the work of giving care to parachutes and barrage balloons. They work inside partially inflated balloons patching the fabric where it has ceased to be gas proof. At the present time there are many all-women balloon barrage teams operating balloons throughout the country. Thus the male members of such teams are released for other types of service.

Three other organizations are open to women (as well as to men) and are all related in some way to the services. They are:

1. The Air Transport Auxiliary, which numbers about 50 women pilots engaged in ferrying airplanes from factories to airdromes, thus relieving R.A.F. pilots for fighting service.

2. The Navy, Army, and Air Force Institutes, which are the officially recognized service canteens. This organization came into being in 1921 as the outcome of the experience of the canteen services conducted during the last war at home and abroad. About half of the N.A.A.F.I.'s 50,000 employees are women. They wear khaki uniforms and are on duty wherever soldiers are congregated.

3. The Y.M.C.A. Women's Auxiliary. Over 50,000 women give their services voluntarily through this organization. Many of them drive or staff the thousand mobile canteens owned by the Y.M.C.A., while others help to staff the static canteens which are open to all members of the services in every nook and cranny of the British Isles.

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A second article by Miss Phillips on British nursing activities, both professional and volunteer, will appear in December PUBLIC HEALTH NURSING.

# The Sulfa Drugs: Nursing Care

By HELEN E. M. PENHALE, R.N.\*

The thrilling tale of the sulfonamides and what they can do for humanity is yet unfinished. But some questions nurses are asking about them are answered here

NO SINGLE discovery in medicine in recent years has so directly affected the clinical course and nursing care of so many diseases as has the advent of the sulfonamides.

With this discovery another occasion arises where the voice of the public health nurse must be competent and informed. The enthusiasm of the public for new drugs is apt to lead to their indiscriminate use, and their administration for long periods in cases where their effects have not been carefully studied may be actually harmful. These represent but two of the problems which confront the public health nurse in relation to the sulfonamides.

## HISTORY

Previous to 1935,\*\* the list of bacterial chemotherapeutic agents was a short one. In 1908 Gelmo, a German chemist, synthesized an azo dye which contained the sulfonamide radical. But not until 1927 were the therapeutic properties of this substance proved. Another German chemist, Gerhard Domagk, while working with various dyes, discovered that mice could be "protected against fatal doses of streptococci" by treating them with the chemical, Prontosil. Chemists at the Pasteur Institute in Paris discovered that the Prontosil described by Domagk was reduced in the human body to free sulfanilamide,

a compound possessing antibacterial properties. Extensive experimental and clinical studies followed, until today we have some 5000 compounds with therapeutic possibilities.

In this country Johns Hopkins Hospital has done extensive research and it is to the members of this institution that we owe the earliest information, in 1936 regarding the bacteriostatic action of the sulfonamides.

Tragedy punctuated the pharmacological entry of sulfanilamide, with the result that further derivatives have been cautiously investigated before being placed at the command of the medical profession for general use. In May 1938, L. E. H. Whitby of London announced sulfapyridine as the effective drug to be used in pneumococcal infections. Almost immediately came other derivatives — sulfathiazole, sulfaguandine, sulfadiazine, and sulfasuxidine.

## HOW THE DRUG ACTS

The action of the sulfonamide compounds is probably twofold: (1) the inhibiting action of the drugs on the microorganisms (2) the stimulating effect of the drugs upon the natural defenses of the body. Their effectiveness may be due to a combination of these two actions. Probably the primary action is one of bacteriostasis which implies an

\*This article has been read and approved by Dr. Champ Lyons, Surgeon, Massachusetts General Hospital, Boston.

\*\*Spink, Wesley W. Sulfanilamide and Related Compounds in General Practice. The Year Book Publishers, Chicago, 1941, Chapter I (Historical Development).

inhibition of the rate of growth of the bacterial cell. There is also some injury to the bacterial cell which permits the normal defense mechanism of the host to destroy the organism by phagocytosis.

It has been found in the studies of the action of the sulfonamides in the body that there are at least two factors which enter into their therapeutic effectiveness. First, it is necessary to subject the organism to a concentration of the chemical that will produce maximal bacteriostasis; and second, the elective action of these drugs for certain types of microorganisms must be considered in determining the correct derivative for treatment of the specific bacterium.

From the numerous experiments performed with sulfonamides, some definite knowledge has been gained as to the specificity of their antibacterial action on various species of microorganisms. Their intelligent use depends upon accurate bacteriological data and accurate diagnosis.

#### CLINICAL USES

Sulfanilamide is effective against the hemolytic streptococci; thus, it is of major use in treating such conditions of hemolytic streptococcal origin as erysipelas, osteomyelitis, otitis media and puerperal sepsis. It is effective in the local treatment of anaerobic infections of the gas gangrene group.

Sulfapyridine is definitely superior to sulfanilamide in the control of pneumococcal and meningococcal infections. However, it is a less satisfactory drug to administer to patients than is sulfanilamide. It is more likely to induce severe nausea and vomiting. Since sulfapyridine is much less soluble than sulfanilamide, a desirable blood concentration of the former is more difficult to maintain. Its excretion by the kidneys in the acetylated form may lead to serious complications of the urinary tract. Although it is effective in the

treatment of gonococcal infections, its toxic effects must be carefully considered.

Sulfathiazole is the drug of choice for staphylococcal infections, gonococcal infections, infections of the urinary tract, and gas gangrene. It seems to be as effective in the treatment of pneumococcal infections as sulfapyridine, and produces much less nausea and vomiting.

Sulfaguanidine and sulfasuxidine are being used in the treatment of dysentery and other intestinal infections. One of the latest members of the group to be used extensively is sulfadiazine. It possesses the bactericidal properties of the other sulfa drugs and is very much less toxic. Sulfadiazine is used for streptococcal, pneumococcal, and meningococcal infections.

#### METHODS OF ADMINISTRATION

Wherever possible, the compounds should be administered by mouth. When clinical conditions make oral therapy impossible, the drugs may be given parenterally. They may be used locally as prophylactic agents to lessen or prevent the incidence of infection in conditions such as burns, compound fractures, and extensive tissue injuries.

The dosage should be determined by the attending physician since so many factors must be considered in prescribing the correct amount. A large initial dose is given to establish an immediately effective blood concentration of the drug. In order to maintain the blood concentration, the drug must be administered at frequent intervals, day and night. In cases of milder tissue infections, a level of from 5 to 10 mg. per hundred cubic centimeters of sulfanilamide in the blood is generally adequate to bring the infection under control. More severe infections require a higher blood concentration. The dosage per pound of body weight required to establish these levels varies with the drug used, the fluid intake, the severity of the infection, and



the aim of the treatment. For example, sulfanilamide is excreted almost entirely in the urine. Therefore, the greater the volume of urine, the greater the excretion of the drug. A large initial dose is indicated in order rapidly to control the bacteria, which multiply at an enormous rate. An adequate level must be maintained over a period of time since too rapid withdrawal of the drug may find the defenses of the body still imperfectly mobilized. A drop in temperature does not indicate that the patient is cured, and the drug should be continued for several days after this occurs.

#### REACTIONS CAUSED BY DRUG

An acquaintance with the various reactions caused by the drug is essential. The mild toxic reactions—including vomiting, cyanosis, and dizziness—are not contraindications to the continuation of chemotherapy. Such manifestations may be only temporary and usually subside when therapy is stopped.

The moderately severe reactions—including delirium, acidosis, skin rashes, and fever—are indications for interruption and possibly termination of use of the drug. The most serious toxic manifestations, which may lead to death, are renal irritation and anuria, severe acute anemia, hepatitis, and jaundice. These reactions may indicate a sensitivity to only one of the derivatives, and the patient may be able to tolerate others without difficulty. The reactions may, on the other hand, indicate a permanent sensitivity to all sulfonamides.

However mild may be the toxic manifestations, the nurse should not be expected to assume the responsibility for interpreting these symptoms and deciding upon their importance. All reactions should be reported to the attending physician and his decision obtained as to the advisability of continuance of the drug.

Patients receiving the sulfonamides require the most attentive nursing care.

In the home, the family must be adequately instructed as to what to expect in the way of untoward reactions. The patient should be visited daily by the attending physician. When this is not possible, the public health nurse must assume more responsibility for the patient. She should visit him daily at least. She must know how to recognize undesirable reactions in order that she may help the family to carry out nursing measures which reduce their occurrence and alleviate discomfort when they do occur.

#### PATIENT SYMPTOMS

Inquiry should be made as to how the patient feels, with special reference to the symptoms of headache and malaise since they are often the precursor of many of the toxic reactions of the sulfonamides. The temperature curve should be followed closely to detect the early signs of drug fever and the family may need instruction in the procedure of taking the temperature so that changes can be detected early.

The sclera should be examined for the presence of jaundice; the conjunctiva, for injection or paleness. The skin should be looked at carefully for the presence of rash. Frequently in the early stages of such a toxic manifestation, this macular eruption may be missed. Exposure to the sun's rays speeds and intensifies this reaction. The patient should be shielded from direct sunlight during the time he is receiving the drug, and for at least three days after the drug has been stopped. The macular eruption which occurs usually at about the fifth to the seventh day of the treatment may be annoying and painful. Rubbing and any irritation of the skin should be avoided. Eye irritation may be minimized by discouraging reading and protecting the eyes from light and by the use of mildly antiseptic eye irrigations.

The urinary output should be checked

at each visit. A diminishing urinary output may be one of the earliest signs of kidney dysfunction. An accurate record of the fluid intake and output should be kept because it is of great assistance in checking on kidney function. Fluids should be spaced through the twenty-four hours to maintain a fairly even drug concentration, and hence prevent kidney irritation during periods of decreased fluid intake. The patient should receive a specified amount hourly during the day and less frequently during the night. An output of 1000 cc is important. To obtain this output, an intake of about 3000 cc is required. Rarely is it necessary to force fluids beyond 3500 cc. Liquids to this level are important because the precipitation of the drug is more likely to occur in concentrated urine and hence there is a greater possibility of renal calculi and renal irritation. Gross hematuria should be reported at once. A hemoglobin test and white blood cell count should be made twice a week as long as the therapy is continued.

Nausea and vomiting frequently occur. Bicarbonate of soda is not indicated routinely either to prevent or control this symptom—although it may help, especially in cases where acidosis is present. The family may be saved much anxiety if they are forewarned that cyanosis is usually observed in patients receiving the sulfonamides. The *blue* appearance may be rather alarming, but is not thought to be of any significance. Temporary mental changes, varying from a slight inability to concentrate to delirium, may cause alarm on the part of the patient's family. Because of these possible symptoms, the patient should be protected from excitement and prob-

ably should be advised against carrying on his work while receiving the drug.

The nurse's responsibility includes instructing the patient and those responsible for his care regarding necessity for accurate administration of the prescribed drug in the correct dosage and at the specified time intervals if the chemotherapy is to be effective. It is important to emphasize that, although a drop in temperature and an apparent subsidence of symptoms occur, the disease may not be fully cured. Continued use of the drug for several days later is necessary.

The diet need not be restricted in any way. Foods such as fruit juices, jelly, or applesauce, may be utilized as carriers for the drug, especially when administering them to children. However, this practice is not always psychologically sound since it may result in the development of an aversion to some essential food. It was at one time believed that sulphur-containing foods and medications were contraindicated while the sulfonamides were being administered. There appears to be no contraindication to the concurrent administration of other drugs, provided there are definite indications for such prescriptions.

Constant teaching is required to discourage the indiscriminate use of the sulfa drugs without proper supervision and trained observation. There can be no question that it is safer to hospitalize patients while they are receiving this chemotherapy. However, due to increased demands upon hospitals, home treatment of the less acutely sick patients will necessarily increase. Proper nursing care of the patient in the home and instruction of the family are very important.

Is every member of the staff of your agency a member of the N.O.P.H.N.? If so, and you have not notified the N.O.P.H.N., do so at once. The complete list of Honor Roll agencies will be published in January 1943.

## Better Health for Farm Families

By HARRIET KIRK GODING

Sickness as well as poverty was a cause of trouble among farm folk and the Farm Security Administration made plans so many can now buy health and self-respect

MRS. RALEIGH HUBBARD stood quietly before the microphone in a Washington, D. C., broadcasting studio. "Now we can call the doctor when we need him," she said, and as she spoke, she put into words the immeasurable relief of more than a hundred thousand American farm women who no longer face the hard decision that must be made when illness comes and there's no money for doctor bills.

For these women and their families—over half a million rural people all told—the Farm Security Administration's medical care program has brought doctor and hospital services within range of their pocketbooks.

Mrs. Hubbard knows what can hap-

pen when you start in search of medical care too late.

"We used home remedies, mostly, before we had a medical care plan," she said. "But home remedies don't do much good when a person's really taken. When my little girl was so bad, the doctor came as soon as we called him. He said if he could have got to her sooner, he thought he could have saved her."

A small woman—she tips the scales at some 90-odd pounds—Mrs. Hubbard told her story to listeners of the National Farm and Home Hour with a simple dignity born of hard work and frugal living. It was her first glimpse of a broadcasting studio, her first trip to the Nation's capital, too, though her



Medical care group members go to the doctor more—call him to their homes less

home in Prince Edward County, Virginia, is no more than a four hours' drive away. But for her the microphone held no terror. She had a message for other mothers like her and she told it.

What had the medical care program meant to her? "It's saved the lives of two of my children. You can judge for yourself what it's been worth to us."

#### THE HUSBANDS MEET A CRISIS

There was the time her son Sam fell off a bicycle and bruised his ankle. "His ankle swelled up and pained him till he had fever and chills. The doctor said it was osteomyelitis. . . . We had to take him to the hospital to be operated on. That was January a year ago. He's had to go twice a week or more for treatments ever since then. But he's working now. And the doctor says he'll be all right. We heard since about two people that died with the same thing."

The Hubbards figured that Sam's operation and treatments would come to more than \$200. But the \$24 they paid into the Prince Edward County medical plan last year took care of everything, even the cost of drugs. Yet the doctor who served the Hubbards and the other

doctors who participated in the county health association collected more than 75 percent of all bills they submitted to the group—considerably more, they said, than they formerly collected from the same families.

How could the Hubbards get \$200 worth of service for \$24? Because some of their neighbors didn't need a doctor last year but paid their \$24 fees just the same. Maybe the Hubbards won't need medical care next year and their \$24 will help pay bills for someone in the group who does.

That's the way the Farm Security Administration's medical care program works, the same as group health insurance. Because average family incomes vary, as well as services covered, membership fees are not the same for all 900 counties where plans have been set up. In some counties annual fees are as low as \$15 for each family, in others as much as \$35 and more. Most plans provide the same services as the one in Prince Edward, which includes physicians' care at home or the office, emergency surgery, limited hospitalization and necessary drugs. But in some plans, surgery is not covered, sometimes hos-



Energies and abilities are slowed up by uncorrected nagging and chronic ailments



Doctor takes health inventory of a family belonging to a county medical care plan

pitalization is omitted. In other plans, though, limited dental care is included, and in some 190 counties families pay and pool separate fees for dental care.

#### FARM INCOMES ARE SMALL

The Hubbards can afford to set aside \$24 or so every year, but a \$200 medical bill for them would be a staggering blow. They are one of the 3,000,000 farm families you'll find listed in the last census, not by name, but as the families who had total farm incomes of \$600 or less in 1939. And those incomes weren't all in cash. They included the value of everything the families raised on their farm, whether for sale, trade or home use. After farm operating and family living expenses were paid, there was little left to spread around for education, medical needs and other things which to most people are everyday living essentials.

You don't have to be an economist to figure out why medical authorities tabulate rural health in red ink. A farm family income of \$600, or even \$1,000 will not stand the strain of an emergency operation. It won't stand the strain of paying for the correction of chronic ail-

ments that have accumulated over a period of years. It won't even stand the strain of regular trips to the dentist, or ordinary medical care for a family of five or six.

It never takes rural workers long to find out that poverty and bad health operate together. A few years ago when thousands of farm families faced defeat, had used up their credit and could turn to no one for more, the Government set out to help these people get back on the track to self-support. It turned the job over to the Farm Security Administration. Part of the Farm Security's job is to make loans for cows, chickens, seed, machinery—whatever a family needs to produce most of its own food and earn enough money to pay expenses and meet its obligations. In nearly every county a man and woman, known as FSA farm and home management supervisors, guide each family to improved farming and home management methods.

#### MEDICAL NEEDS ARE GREAT

Working day in and day out with people who were trying to make ends meet and get ahead, the supervisors soon traced many troubles to their source. Bad health, they learned, could be the cause as well as the result of poverty. John Murphy was "just plain lazy," his neighbors said. But hernia was John's main trouble. And there were a good many John Murphys. Not all of them had hernias, of course, but "just plain lazy" people often were just plain sick people. Their energies and abilities were slowed up by nagging, chronic ailments they couldn't pay to have corrected.

Once somebody got a bad case of appendicitis, though, or a cold turned to pneumonia, they did what they had to. Some went to a county hospital ward. But most families called the doctor and worried about the bills afterward. Sometimes they sold farming equipment to settle them, sometimes they had to let them go unpaid.



It was a bad situation all around. A questionnaire was sent to Texas and Oklahoma farm families who had borrowed money from the Farm Security Administration. About 43,000 answered. Out of 16,000 cases of serious illness reported for the year, less than half were attended by a physician. One out of every three children was born without medical care. Yet doctors who served these people were holding a sack filled with half a million dollars worth of unpaid bills.

FSA field people did the best they could. They helped families figure out how to produce enough food for three good meals a day, worked closely with county welfare agencies and public health nurses to make the most of whatever assistance was available. In making up budgets for farm and family living expenses, some \$20 or \$30 was allowed for medical needs. But free rural health services were limited, and medical care could not be budgeted because it was not possible to predict the need for it.

In one year about 300 Michigan families failed to make a go of farming even with FSA loans and guidance. Some were unable to find farms to rent, some found jobs in industry, but one out of every five failures was caused mainly by bad health.

A year or so of such experience indicated the remedy, and in 1936 the U. S. Public Health Service lent the services of Dr. R. C. Williams to help work out a plan of group health insurance. Dr. Williams had been a country doctor himself and knew that rural practice wasn't always what it was cracked up to be.

He and his staff went straight to state medical associations and local doctors, asked for their approval and cooperation before setting up a plan in any county. The plan itself was worked out to retain the basic features of traditional medical practice.

#### LOCAL DOCTORS MAKE PLAN

Instead of following the pattern of most former medical care organizations and hiring certain doctors to serve a group, every legally qualified physician in a county is asked to participate in the FSA plan. Members have their choice of those who do, physicians reserve the right to serve or not to serve, and the much talked-about doctor-patient relationship is maintained.

Too, physicians still charge on a fee-for-service basis, but agree to accept pro rata payment on their bills if pooled funds are insufficient for coverage in full.

Details of organization vary to fit local conditions. But annual fees always are paid in advance and usually divided into 12 equal parts so that bills can be paid once a month. Where hospitalization is provided, about 30 percent is set aside for hospital charges, 50 cents to \$1 of each fee is used for administrative expense and the rest goes to the doctors. If families don't have money on hand for fees, the amount is covered in FSA loans, to be repaid along with the rest of the loan.

A bonded treasurer or trustee has charge of all funds. Otherwise, operation of the program is up to the two groups directly concerned: the members who elect a board of directors to represent their interests; and the doctors who elect a committee to review all bills and handle other problems of a medical nature.

#### THE PLAN CATCHES ON

This program has caught on. Families who used to go without a doctor rather than take "charity" are now getting regular medical attention, and paying for it.

There have been some complaints. One man said he didn't think he would join the medical plan, "because on the average we don't use more than sixteen

dollars' doctoring a year, and we don't think we can save by joining."

Another FSA borrower who had joined a dental care group wanted a cavity filled with gold. The dentist said gold fillings weren't in the bargain, and amalgam was just as good.

"Well, if I can't get a gold tooth, I don't want any," the farmer said. "I knew there was a catch in it somewhere."

But most families feel the same way as the DeMarco family in New Jersey. "We didn't have a doctor at all the past nine years," Mr. DeMarco said, "except three years ago when Joe had died of lockjaw. If we'd of had the doctor in time, maybe our boy could've been saved. Now, it's different. My wife here has been laid up with heart trouble and if we didn't have a medical plan she couldn't get to the doctor. We had a bad year. The fruit didn't bring much and the tomatoes was spoiled by the weather. You never know what you might run up against."

It's the security they seem to like best. One woman in Colorado said, "It sure takes off a lot of worry. You don't have to wait until a person's down sick before you call the doctor. Last year, Roberta had a bad earache. The doctor lanced it. He said if it had been let go, it would have been mastoid."

And the doctors—how do they like the plan? Some don't. In a recent letter, one midwestern doctor said: "This service has been a very worth-while project in relation to the members, but I do feel that it has not benefited the doctors. . . . (In private practice) it would leave the decision entirely with the doctor, whether or not he wished to do the work for this type of individual. He can control this by demanding payment of bills before any great amount of credit is given."

Fortunately for the sick people of this world, not all doctors hold the same view. Most doctors in rural areas have

served "this type of individual" for years with little or no remuneration. This is one reason why most of them are strong supporters of the FSA program, why some of them have even been instrumental in getting it started.

#### A.M.A. APPROVES

At its last annual meeting, the American Medical Association adopted a report expressing "highest approval" of Farm Security Administration's policy of arriving at understandings with state medical societies before making contracts. The report states further, "Your reference committee notes with pleasure the report of the rehabilitation work. . . . Any attempts to restore health and self-respect to American families and to preserve individuality, independence and security is to be commended."\*

Doctors who participate in the program find that it automatically prevents many cases of serious illness. Said Dr. Theodore S. Paulson of Otter Tail County, Minnesota, in a recent radio interview: "At first, we wondered if people would go to the doctor when it wasn't really necessary just because there would be no extra cost. Well, as it worked out, they did go to the doctor more, but they called him to their homes less. Out of 257 calls over a 3½ month period, only 13 were home visits."

#### THEY EMPHASIZE PREVENTION

And usually the doctors don't leave preventive measures to chance. Because they can collect no more than the amount in the pool, they have a direct interest in keeping people well. Working together, the doctors in one county, for example, asked all group health members to be home on a certain day and then made the rounds to take a health inventory. They left many sug-

\*"Report of Reference Committee on Legislation and Public Relations." *The Journal of the American Medical Association*, June 21, 1941, p. 2795.

gestions and not a few prescriptions.

In another county, doctors wrote letters asking members to attend the county health department clinics for examination and possible inoculations and added that "this is of special importance now, due to the fact that epidemics are much more common in time of war."

The Farm Security Administration also has contributed much toward disease prevention among low-income families. Its emphasis on better diets brought forth comment from one southeastern Missouri physician to the effect that families who had been farming with FSA assistance the longest had the least anemia. Farm Security also has helped about 75,000 farm families to improve sanitation facilities—73,000 of these have built good, tight privies; 35,000 have screened their homes; and 32,000 have safeguarded sources of drinking water.

That this health work has brought results is indicated in a survey of draft board records in four southern States. Up to December 15, 1941, a total of 36 percent of all draftees in South Carolina, Georgia, Florida, and Alabama had been rejected because of physical defects. But of the young men from FSA families in that group, only 23 percent were rejected.

#### BUT MORE CAN BE DONE

But the FSA medical care program is not claimed to be a cure-all for rural health conditions. For one thing, membership fees are set at a level the families can afford. In only a few counties are they high enough to pay doctors for correcting chronic conditions. To get an idea of the amount of corrective work to be done, complete physical examinations were given in 1940 to all FSA borrowers and their families in 21 typical counties of 17 states. Out of nearly 12,000 people examined, only four in every hundred were in topnotch physical condition, and

an average of  $3\frac{1}{2}$  defects was found for every man, woman and child.

Among the most prevalent defects: Seven out of every 10 persons over five years had decayed permanent teeth; more than half of all people examined had defective tonsils; one child out of every 12 was malnourished—one in every 17 had rickets or showed after-effects of rickets; 40 percent of all wives were suffering from second or third degree injuries resulting from child-bearing; one out of every 12 husbands had some type of hernia.

What can be done to strengthen rural manpower when fees are high enough to provide unrestricted services is demonstrated in several Great Plains counties. Here the doctors are carrying on a physical rehabilitation program, without additional cost, for rejected draftees as well as boys from the ages of 16 to 21.

#### GROUP MEDICAL PLANS ARE SPREADING

So far, membership in FSA group medical care plans has been limited mostly to farm families who have borrowed money from the Farm Security Administration. But this rule is beginning to break at the seams. In several counties, the doctors themselves already have opened membership to other low-income farm families in the area, and pressure to widen the program is becoming increasingly insistent from welfare workers, local agricultural planning committees and others interested in rural health and welfare.

Their arguments are based on the general low level of farm incomes and lack of rural health facilities. Only half the country's counties have hospitals; public health services are still lacking in 1,400 counties; doctors and other professional people have always been scarce in rural areas and are becoming even more scarce because of war demands—some physicians are trying to serve anywhere from 2,000 to 4,000 persons

and many rural counties are without doctors at all.


Although low-income groups spend a larger percentage of their incomes for medical care, they do, of course, spend much less in dollars and cents. In 1940, farm families with net cash incomes of \$250 and less had medical bills amounting to 23 percent of their incomes. On the other hand, a recent survey shows that families whose incomes range from \$500 and up to \$3,000 spend only four percent for medical needs. But four percent of a \$3,000 income is \$120, and low-income farm families whose medical bills came to 23 percent of their total

cash incomes in 1940 got only \$29 worth of medical services.

Somebody has added and subtracted all these factors—indices of needs as set forth by medical and public health authorities in relation to amounts spent for medical care and facilities available—and has reached the conclusion that 75 percent of all farm people do not have medical service of minimum adequacy, and that over 95 percent do not have full, high standard medical, dental, hospital, nursing, and drug services.

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Pictures are by courtesy of the Farm Security Administration.



### BEAN CROCK MAKES GOOD INHALATION KETTLE

SOMETIMES the public health nurse has difficulty in finding a pitcher or suitable kettle for giving inhalations to a patient in the home. Almost every family—especially in rural areas—possesses a bean crock. A two-quart size is satisfactory for giving the treatment, but a gallon size is still better because the solution in a large kettle will stay in a steaming condition for a long time.

The bean crock is placed in a paper shopping bag, or a large ordinary paper bag, and set on a low chair or footstool near enough to the patient's bed so that he can easily turn on his side and put his head in the top of the paper bag. The patient's eyes may be covered with a handkerchief to prevent irritation, and

his head should be covered with a turkish towel to prevent chilling and to use the inhalation to greatest advantage.

The same method of inhalation may be used for a young child. His crib is covered as usual in inhalations, and the steam is directed under the tent from the bean crock by placing the mouth of the paper bag near the head of the crib.

This method has several advantages. The solution stays hot longer than it does in a lighter receptacle. The danger of the kettle's overturning and burning the patient is eliminated. And the articles needed can usually be found in the home.

CATHERINE L. AUSTIN, R.N.  
*Boston, Massachusetts*

# Volunteer Help in a Maternity Program

By ELIZABETH POPE BEHR

THE MATERNITY CENTER Committee of the Visiting Nurse Association of Brooklyn carries on a program which is closely integrated with the whole generalized program of the organization. This is in keeping with present-day recognition that maternity service cannot be separated from other nursing activities, because the mother must be considered in relation to her entire family. For this reason the work I describe includes not only the maternity committee work in which I have a part but other voluntary activities carefully tied in with the generalized program.

The Committee is an outgrowth of the twenty-five-year-old Maternity Center Association which in 1935 merged with the Visiting Nurse Association in the interest of one unified community nursing service. The program of the older Maternity Center Association continues as a divisional activity of the Brooklyn V.N.A. The work of this volunteer group is under the general guidance of the director of the Visiting Nurse Association.

## VOLUNTEER APPRENTICESHIP

The fact that virtually all of our committee were members of the older group and came to the new setup with a real knowledge of public health nursing policies and practices has been of special advantage. We had all been close to our nurse director, from whom we received invaluable information and training. I believe our usefulness has been largely due to this opportunity to listen, study, and think under such close expert guidance. The nature of the program had necessitated elasticity in choice of activities. We could not work year after year

on the same projects without being sensitive to changing needs. In our frequent conferences we discussed our maternity service in great detail. We learned the basic principles of public health nursing, and maternity nursing in particular, and based our decisions concerning the service, and about such details as hours of work, salaries, and vacations, on these principles.

Our maternity nursing consultant saw to it that we looked up the local, state, and national maternal mortality rates, so that they were impressed upon our memory. It was interesting to us that since our founding in 1918 the infant mortality rate for New York City dropped from 91.6 per 1000 live births to 35.0, but we were taught not to make undue claims of accomplishment! We learned the vocabulary of our subject, in order to understand what was written about it, if not too technical.

In the study of qualifications for public health nurses we found that there are never enough well-prepared nurses, and that we must therefore plan for training on the job. We studied salaries, noting the relative costs of living in our city. We attended meetings of other agencies to learn their programs, and studied the place of ours in the community program. We followed the nationwide campaign of the Maternity Center Association of New York City for better maternal care, and visited their outstanding exhibit at the World's Fair. We studied relief-giving, and learned to avoid giving material relief except in special instances, because if we did patients would look to the agency for financial aid rather than for the nursing care which it was our primary function to furnish.

A formal introduction to the work for



new board and committee members came to seem desirable. They were asked to come to headquarters to see the exhibits, look over "Routines and Procedures" and other materials used in the work, and hear the professional service explained by the director. They were asked to read the *Board Members' Manual*\* and PUBLIC HEALTH NURSING magazine, and other books and periodicals on nursing. We explained the responsibilities of these new members, and urged them not to spread out into too many activities, but to become proficient in one or two.

#### PRESENT PROGRAM

At present under the auspices of the Maternity Center Committee some of these same activities are still carried on. The Committee meets monthly. Ample time is given for the report of the maternity nursing consultant, and this is followed by questions and discussion. Attendance is excellent and interest is keen. Through this Committee I believe we are able to give our professional staff a much-needed sense of support. They wish us to understand the reasons for the decisions they must make as well as for decisions made jointly by our group together with the staff. It might seem that our able director and supervisors do not need us but we know this is not true. Some years ago I recall hearing Elizabeth Fox say that the function of board members at times is to compensate for the blind spots of professional people, and their only human one-sided stresses. Some parts of the work, lay members by virtue of varied social and practical experience may do even better than the staff.

One example is the stimulation of community interest in the work through channels other than formal publicity.

\*National Organization for Public Health Nursing. *Board Members' Manual*. The Macmillan Company, New York, second edition revised 1937.

What some of the Committee have done to interest other individuals can never be measured. An annual theater party held for many years brought not only money but friends who became permanent givers and workers. We took pains in this connection to describe the service to those who attended. A women's dress shop run for several years largely by volunteers provided a substantial sum annually, and on closing left us our present reserve fund. Another example is the annual Mother's Day luncheon held jointly with the Committee on Maternal Welfare of the Medical Society of the County of Kings. This has been the only public occasion in our city for stressing the needs and accomplishments in maternity care. A number of committees worked on speakers, newspaper and other publicity, invitations, and an exhibit for the luncheon meeting.

The original Maternity Center group was fortunate in securing as a Medical Advisory Board a group of distinguished obstetricians. The help they gave is continued now by the Committee on Maternal Welfare of the county medical society. They have taught us much and we have been able to lend them personnel for their study of maternal deaths.

The Visiting Nurse Association receives its principal income from the United Hospital Fund. The Maternity Center Committee furnishes four teams of ten members each to help in the Fund's annual drive. Besides this means and the funds provided from the dress shop, the Committee now shares in the profits of a thrift shop which is run by a number of agencies. We collect and sell rummage and assist in the management of the whole project. Benefit bridge parties are another source of funds for the Committee.

#### ACTIVITIES IN VARIETY

Various minor activities are carried on in connection with the program. We visit the mothers' classes inconspicuously

in small numbers. We assist the secretary to welcome and register the mothers. One of the committee recently visited classes conducted by other agencies for the purpose of comparison. Some members make posters for the classes and others cut out paper patterns of dresses for the babies and binders for the mothers. These are sold to patients for two cents each.

Recently a member lent her car to take a prospective mother to a hospital clinic. It surprised her to see that young and attractive woman, though her legs were paralyzed from infantile paralysis in childhood, swing herself into the car on her crutches. She had implicit faith in her doctor to bring her through the ordeal before her—and no doubt the visiting nurse had something to do with this. We are pleased to hear that she and her husband are now very happy with their baby. Perhaps we have gone too far away from personal contact with the people we are helping, and are working too exclusively through our professional staff.

The committee gave a collection of books on maternity care and allied subjects to the professional library of the Visiting Nurse Association for the use of all the nurses.

With great pleasure we meet the staff at occasional parties and sometimes in our homes, and wish time allowed for more of this. We joined our staff in celebrating Christmas and this suggested that perhaps board members might give some real assistance to new nurses in the city by directing them to sources of recreational and cultural activities. As a small contribution, we made a file of things to see and do in New York City, placing a copy in each of our eight sub-stations.

Each board member has some special job. Mine happens to be speaking to

church and parent groups about the work of the Association. The talks are illustrated by the moving picture, "Sickness Takes No Holiday," or by colored slides of nurses on their visits.

#### BUILDING FOR THE FUTURE

How can we improve this lay volunteer service?

We can bring larger qualities to it, greater devotion, understanding, imagination. Our thinking should go far ahead of immediate plans. Some years ago at the twenty-fifth anniversary of the National Organization for Public Health Nursing, Mrs. Chester C. Bolton said, "I look forward to the time when one can pick up a telephone and say, 'I want a nurse.'" This would mean the realization of the fact that all types of nursing service should be pooled and distributed in a way best to serve the community.

We can fit the individual better to her job. Her ability should be studied in the light of the task to be done. For lack of this we have sometimes wasted time and energy. Workers should be made to feel that any needed piece of work, no matter how small, is vital. We realize more clearly every day the usefulness of special training.

It may be necessary in the nursing shortage for lay people to take over every part of the work not strictly professional. Perhaps we should set up brief training courses for these jobs. Certainly women already trained in speaking, typing, filing, and other skills will be doubly useful.

Now particularly, participation in educational maternity services is a great privilege. We need make no apology for continuing them in wartime—present conditions call for them more than ever. We only hope that no hard necessity will curtail them.

# Group Teaching by the Nurse

By MARY M. DUNLAP

**That the public health nurse has a function as teacher is common knowledge. Here are some good principles and effective methods of group teaching not so well known**

**N**URSES ARE being called upon today, as never before, to help maintain and improve the health of our people by teaching various groups the fundamentals of healthful living. For many nurses this is a new undertaking, for which they do not always feel adequately prepared. They are seeking help in the solution of their numerous problems, for they are eager to make their teaching as effective as possible. Whether they are asked to participate in the health-education program in schools, to teach classes for expectant mothers, or to work with groups in home nursing and first aid, they will want to be familiar with certain fundamental principles which can be applied in any situation.

One of the first problems confronting the nurse in group teaching is that of organization. Often she is asked to work with an existing group, but if she is privileged to help select the members, there are certain factors to be considered which will contribute to the success of her undertaking. The nurse who is beginning will not want to work with too large a group—perhaps not more than twenty. True, she is often under pressure to enroll large numbers, but she should ask herself whether her goal is exposing many people to health information or helping fewer people to learn how to solve their own health problems. Then, too, the group should be as homogeneous as possible, with somewhat similar backgrounds of experience, education, and interests.

Preparation for the course includes provision of suitable physical facilities. It is difficult to teach effectively the importance of conserving vision in a room where all the principles of good lighting are violated; or to teach the relationship between posture and health in a room where the seating arrangements make good posture almost impossible. Other matters to be considered are the number of sessions to be included in a given course, the length of the class period, and the time and location which will be most convenient for the group. These questions will have to be decided in the light of the varying conditions which are met. The plans might be quite different in a rural situation than in a small town or city where transportation is not a difficult question.

## KNOW YOUR GROUP

The nurse is next concerned with acquiring as much information as possible about the various members of the group in order that she may plan for them wisely. At the time of registration it may be advisable to have simple questionnaires filled out which will give such items as occupation, education, nationality, magazines and radio programs enjoyed, living conditions, family status, and reasons for enrolling in the course. The questions should be general rather than personal in character, so that the group will have no reluctance in answering. From such questionnaires the nurse can gain a helpful picture of the economic, cultural, and

educational backgrounds of the group, together with some indication of the interests of the various members.

At the first meeting of the class the nurse might present a quiz program or an "information please" program similar to those used in popular magazines or over the radio. Short-type questions and problem situations could be used which would bring out in some degree the amount and kind of knowledge possessed by the group. Such a plan would need to be carried out very informally and the purpose carefully explained; otherwise a feeling of insecurity and tension might develop.

If the nurse has been working in a community for some time, she will be familiar with the backgrounds and problems of the individuals in the group. For example, a nurse in a rural county was asked to conduct a series of classes in foods and normal diet for the teachers in the rural schools. She had been working with these teachers for some time and knew exactly what their problems were and what constituted their knowledge of nutrition, so that she already had a basis upon which to build.

#### PLAN THE COURSE OF STUDY

The third problem has to do with planning the course of study. Every nurse will want to work out her own plan. To study plans which have been used successfully by others is very helpful; but to take over *in toto* a plan which has been worked out for groups in general or for any specific group is to violate all educational principles.

Today's educators tell us that learning means change, whether it be change in attitudes, skills, or habits. The nurse, then, will study her group, decide what changes in attitudes, skills, or habits are desirable, and seek to discover how she can best bring them about, keeping in mind the needs, backgrounds, and interests peculiar to her group.

This brings us to a discussion of ob-

jectives or goals as related to course-planning. In teaching—as in any other undertaking—it is important that goals be clearly defined through a study of the needs of the group and the achievement possible for them. The experienced teacher may be able through skillful questioning and discussion to help the group work out its own objectives, or at least to help the members broaden or extend their goals.

The members of one group had said, for example, that they wanted to know what vitamins were. After some discussion led by the teacher their goal was stated to be: to acquire an understanding of the function of vitamins in a well-balanced diet. Subsequently this was broken down into lesser or contributory objectives. But whoever sets up the objectives, it is essential that the group—as well as the teacher—have a clear understanding of the goals toward which it is working. These objectives should be specific, should be simply expressed, should furnish a challenge, and should have meaning or value to the group.

#### SELECT THE CONTENT

The next step in course-planning is the selection of course content. The nurse will want to choose the content which will best achieve the desired goals in terms of the interest and background of her particular group. Let us suppose, for example, that some such objective as this has been set up: to acquire an understanding of what constitutes sound personal hygiene. Obviously, the nurse who is helping a group of high-school seniors to achieve this objective will select a sort of content very different from that she would choose for a group of middle-aged women with children. The nurse needs a very extensive body of knowledge from which to draw information that will best suit the different groups with whom she works. This may mean considerable reading on her part—especially if she has not been active in

nursing for some time—in order that she may be informed on the most recent developments in the realm of health conservation.

#### CHOOSE METHODS OF PRESENTATION

The nurse is next concerned with the best method of presenting the material selected. No one method is the answer, for here again the nurse must consider the background and interests of the group as well as the type of material to be presented. To illustrate, let us take two situations from real life.

A group of young mothers asked the public health nurse in their community to give them classes in the control of communicable disease. They wanted to know more about that problem in relation to the needs of their own families and the community. They were intelligent, interested women, with a good educational background. The nurse in this instance did not have as an objective the awakening of the group's interest in the problem; these women were already interested and eager to learn. Her first class consisted of a carefully prepared lecture on the extent of the problem of communicable disease, its causes, means of spread, and the like. This group was accustomed to the lecture method in general education. There was no problem of interest span. And the group left the classroom feeling that satisfactory groundwork had been laid for answering many of their questions.

Another public health nurse was asked by a settlement worker to teach a group of mothers whose families attended the settlement. The worker knew that these mothers had little understanding of communicable disease and often sent their children to the settlement when they were a danger to others. The nurse found herself working with a group whose educational background was limited, who were not accustomed to formal instruction, and who seemed to have little interest in the problem. The lec-

ture method would probably have produced no change either in attitude or action within this group. But the nurse began by having the mothers discuss a current epidemic of measles in the neighborhood. Soon they were talking about other communicable diseases which often occur in children. The nurse then asked the mothers to bring to the next class meeting a list of their children's names and the diseases which each had had. Some very peculiar items appeared on the lists, but the group had become interested, and an excellent basis had been created for dealing with various aspects of the problem, such as immunization and isolation. This method, on the other hand, might have left the first group bored and feeling that valuable time had been wasted.

#### SEVERAL METHODS MAY BE COMBINED

To illustrate further, let us assume that one objective which has been accepted by a specific group is to acquire the ability to make a satisfactory bed for a sick person. As the first step, the nurse might help to start group discussion by such questions as:

1. Which is more important, a comfortable patient or an attractively made bed?
2. Can we secure both at the same time?
3. What factors in the way a bed is made would affect your comfort if you were ill?
4. How could you save time and effort in making a bed?
5. By what means can the bed be protected?

The nurse would list the various suggestions on the blackboard, eventually arranging them in some sort of sequence. Through this type of discussion the members of the group would be prepared for intelligent observation and would achieve considerable satisfaction from having participated in working out the important things to be considered in making a bed.

The nurse would next demonstrate how to make a bed for a person who is ill, making sure that all members of the group could see what she was doing, and



working slowly so that all would be able to follow her.

More discussion might follow in order to make certain that all the important points had been made clear and that all the group really understood what had been demonstrated. Here such questions as these might be used:

1. Would this bed meet with your ideas of what a comfortable bed should be?
2. Is it neat and attractive?
3. Does it meet the specifications which were set up?
4. How were time and effort conserved?

Using the lecture method, the nurse might then summarize the material which had been covered, emphasizing the main points to be remembered. The group would be given an opportunity to practice the procedure, with the nurse ready to answer any questions which might arise. In this instance, the nurse has used several methods in the same class period, all of them helpful in achieving the desired goal. She will need to be familiar with many different methods: will need to know how to use them effectively; and will select those which will best help to achieve the objectives desired.

Learning is often quickened through the use of visual and other teaching aids. The nurse will find these tools valuable in helping to create interest, in giving emphasis to important points, and in helping to explain material with which

the group may be having difficulty. There are numerous sources from which teaching aids can be secured, but whether one uses films, printed materials, posters, or charts, one must make certain that they are accurate and that they are suited to the subject matter and to the group.

Another problem which always confronts the nurse who is teaching is that of measurement or evaluation. This subject, however, has been covered adequately in an article by Anna C. Gring which appeared recently in *PUBLIC HEALTH NURSING*.<sup>1</sup>

#### SUMMARY

Group teaching presents three main problems, those of: (1) organization (2) group analysis (3) course planning. Planning the course includes the setting up of objectives or goals in terms of the needs of the group; selection of content in terms of those objectives and the interests of the group; a choice of method or methods best suited to the material that is to be presented and to the background of the group; and careful evaluation in terms of the original objectives. Successful teaching of groups comes with experience, but the thoughtful study of some of the broad principles which underlie all sound educational practice will help the nurse achieve results which are satisfying and worth while.

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# Construction of an Examination

By CECIL R. BROLYER

**M**OST EXAMINATIONS are constructed more or less of whole cloth, *i.e.*, somebody sets himself the task of concocting items or questions which he thinks the examinees ought to know. And then without testing the items, he asks the examinees to answer these questions and proceeds immediately to use the responses as a basis for statements about the examinees, the examination, or both. It is the writer's contention that such a procedure is particularly invalid and irrational when it is applied to the development of examinations for a merit system. Before an examination should be used to *test* examinees, it should itself be *tested*. Therein lie many headaches.

If an examination is to be constructed of pretested questions and, further, if it is to be so constructed that valid meanings or inferences can be attached to various levels of achievement on the test, then the construction of the test can be separated into two main divisions: (1) the construction and investigation of the items (2) the compilation of the examination from pretested items. If the items have been properly constructed and adequately pretested, experimental evidence is available that those who answer the more items or questions correctly are the better qualified competitors. If the examination has been correctly compiled for the purpose at hand, experimental evidence is available as to: (1) the expected average performance on the test (2) the expected variation of performance on the test and (3) the meanings in terms of performance on the job that can be attached to various levels of achievement on the examination.

The extent to which a merit system can carry out such a rational development of an examination is dependent upon many factors outside the field of psychometrics. Few, if any, present-day merit examinations in any field are compiled of pretested items.

## CONSTRUCTION OF ITEMS

This article will be restricted to a discussion of items in which the competitor responds by selecting an answer rather than formulating one in his own words. The principles under discussion, however, can be applied to any type of item.

At first, the item constructor has nothing on which to work except his intuitive judgment. He sets up an item and guesses that those who respond to the item by selecting the expected answer as the correct answer will, on the average, be better qualified competitors for the job than those who respond by doing something else.

For example, let us assume that one of the first items constructed was a sort of vocabulary item in which the competitor was expected to demonstrate that she had an understanding of the meaning of the word *thrombus*. Of course, adequate instructions must have been given to the competitors so that they had a thorough comprehension of the manner in which they were to exhibit their understanding of the meaning of the word *thrombus*. Let us assume that the first item developed was:

- thrombus
1. a preparation of animal thyroid
  2. a tumor composed of new-formed blood vessels
  3. functional deficiency of blood platelets

4. a blood clot remaining at the point of origin
5. a wandering blood clot

The task of the competitor was to select that phrase which she thought was the best definition of the word *thrombus*. If the item is to be used in an examination for nurses, the item constructor may have thought somewhat as follows:

Thrombosis is an important term for a nurse to know. If a nurse does not know the meaning of thrombus or if she does not know the difference between a thrombus and an embolus, it is likely that she is not so well qualified as one who does.

Any one or any combination of such ideas may have entered into the development of the item. Suffice it to say that the item constructor had set up a situation to which the better qualified nurse was expected to respond by selecting choice four as correct. The nurse who was less well qualified or who was guessing was expected to omit the item or to make some other incorrect choice. But do nurses really react in this manner? If there were to be no experimental investigation of the item, there would be no evidence that any of these aims was being achieved. Arguments pro and con could, of course, be verbalized about the efficiency of the item, but if no experimental evidence were to be had, the decision would probably have to be given to the disputant who argued with the greater vehemence or otherwise exerted the more force.

If the item constructor were interested in obtaining experimental evidence as to the efficiency of the item, a large number of nurses, representing a random sample of their profession would have to be given an opportunity of answering the item. Responses to the item would have to be compared with the judgments of the qualifications of the nurses. Needless to say, these judgments of competence would have to be made with-

out regard to the nurses' responses to the item. Likewise these judgments would have had to be made by persons competent to judge qualifications and competence as nurses. Such judgments are likely to have a high experimental error. That is, the variation in the judgments assigned to one nurse is so large relative to the variation among judgments assigned to the entire group of nurses that little credence can be placed in a single judgment. As a result thereof, a first step in the investigation is usually to ask the item constructor to develop a large number of items, each designed to separate the better qualified nurses from the less well qualified ones. Performance on all of these items is used as a first approximation to an index of the competence of the nurse; the items that are poor differentiators are discarded; an examination is then constructed of the discriminating items, and performance on this examination is compared with estimates of qualifications or competence of nurses. It is upon such a comparison that the validity of the items and of the examination is ultimately dependent.

For example, the item on *thrombus* was one of 109 such items that were answered by 214 nurses at the experimental investigation carried on at the 1942 Biennial Convention of nurses. The question now to be answered is: *Do the nurses who did better on the total test of 109 items answer this item in the expected fashion?*

This criterion is *necessary*; it is not *sufficient*. It is possible that the item constructor may have gone completely haywire and constructed items such that the total score was more of an index in ability at physics rather than ability at nursing. But whatever the ability which is to be "tested" by the total examination, performance on each individual item must tend to conform to performance on the test as a whole; otherwise the item is introducing extraneous fac-

TABLE I. RESPONSES MADE TO THE ITEM (thrombus)

	Choice No. 4 (correct)	Any incorrect response	No answer	Choice No. 1	Choice No. 2	Choice No. 3	Choice No. 5
N	115	99	2	0	6	0	91
M	13.2	12.8	9.5	—	10.7	—	13.0

N—refers to the number of nurses making the response listed at the head of the column.

M—refers to the mean score on the total test of the nurses making the response listed at the head of the column.

tors into the candidate's score. It was to avoid this "completely haywire" difficulty that each time the item constructor constructed an item she was expected to ask herself the question, "Do I believe that the better qualified nurses will answer this item in the expected fashion whereas the less well qualified ones will not?"

Another factor that prevents agreement between performance on the individual item and performance on the total test as determined in this preliminary investigation from being a *sufficient* criterion of the usefulness of the item was the lack of information about the group taking the test. Did they truly represent their profession? Or, did they tend to represent the better qualified levels of their profession more than the less well qualified levels? Or, was the reverse true?

In the preliminary investigation held at Chicago, the scoring system was such that the mean, (the arithmetic average of the 214 scores) was 13.0, and the standard deviation (a measure of the way in which the individual scores were distributed above and below the mean) was 4.1. The lowest score was 3, and the highest score was 22. Between the scores of 7.5 and 17.5 were included 151 or 70.6 percent of the 214 nurses taking the test.

Attention can now be directed toward performance of the nurses on the item about *thrombus*. Table I presents a partial picture.

It shows that, relative to the variation of all the scores, there is too little dif-

ference between the means of those who answer the item correctly and of those who answer it incorrectly for us to consider this item as a satisfactory one.\*

If the item is studied further to see why it is not satisfactory, it can be seen that the group selecting Choice 5 (91 out of 214) do almost as well on the total test (13.0 as compared with 13.2) as do those who selected the expected answer. It would do us little good to argue that nurses *should know* that a thrombus is a blood clot remaining at the point of origin whereas a wandering blood clot is more appropriately called an embolus. The item simply does not differentiate the better nurses from the poorer nurses as represented by scores on the total test. Of course, it could be said that this particular item was valid and all the rest of the test wrong.

Although items that do not differentiate the better competitors from the poorer ones should not be used in bona fide examinations, such items might be of interest to teachers. If we believe that certain people *should* react in one way whereas others *should* react in another way and if we find on investigation that such is not the case, then it is time for us either to modify our beliefs or to discover why the reactions are different from what they *should* be.

Examples from the Chicago experiment will now be shown of items that

\*More information with regard to this method of item analysis can be obtained from "A Study of Error" by Carl C. Brigham. College Entrance Examination Board, New York, 1932.

TABLE II. RESPONSES MADE TO THE ITEM (palliative)

	Choice No. 3 (correct)	Any incorrect response	Answer omitted	Choice No. 1	Choice No. 2	Choice No. 4	Choice No. 5
N	165	49	3	13	19	0	14
M	14.2	8.9	5.3	10.3	7.6	—	9.9

N—refers to the number of nurses making the response listed at the head of the column.

M—refers to the mean score on the total test of the nurses making the response listed at the head of the column.

might possibly be good items for use in an examination. The word *possibly* is used because, as was pointed out earlier, the criterion that was being used in this preliminary investigation was a necessary one—not a sufficient one. Eventually performance on the items and on the examination would have to be checked against performance on the job. During this preliminary investigation of items it was not known to what extent the test as a whole indicates competence. Also, the group answering the test may not have been a random sample of their profession. It should also be noted that the item was being compared with a criterion, namely score on the total test, of which it was a part. Thus there was bound to be a slightly higher correspondence between performance on the item and performance on the criterion (total test) than if the item were not a part of the criterion. If the investigation of the items and examination were to progress, more careful consideration of such factors would have to be made. It should be noted that this evaluation of performance on the job is simply an index on another type of examination—generally a rather informal one.

- palliative 1. quality of being sensitive to vibrations  
2. causing pallor

3. an alleviating medicine  
4. referring to the covering of the cerebrum  
5. relating to the measurement of the pressure that can be borne without pain

The item "palliative" (Table II) is rather an easy one—it was answered correctly by 77.1 percent (165 out of 214) of those taking the test. The difference, however, between the mean score of those answering the item correctly and the mean score of those not answering the item correctly (14.2 minus 8.9) was such that the correlation of performance on the item with performance on the total test was satisfactory.

- gravity 1. the force that tends to draw all bodies together  
2. a grave condition of the patient  
3. condition of being with child  
4. negative prognosis  
5. morbid increase in weight

If this item "gravity" (Table III) is studied only as a whole, it would appear to be satisfactory for use in the examination since the difference between 14.1 and 10.9 is sufficiently high for the correlation between item and total test to be satisfactory. The writer would, however, like to call the reader's attention to the fact that there were eight nurses with a mean score of 14.6 who

TABLE III. RESPONSES MADE TO THE ITEM (gravity)

	Choice No. 3 (correct)	Any incorrect response	Answer omitted	Choice No. 1	Choice No. 2	Choice No. 4	Choice No. 5	Two answers
N	139	75	4	43	13	8	6	1
M	14.1	10.9	9.5	10.7	10.0	14.6	9.8	14.0



chose choice 4 as the expected answer.

No explanation is available as to why this group thought *gravidity* meant *negative prognosis*. The writer would, however, hesitate to use this item in an examination until further evidence indicated that it was just a chance occurrence that eight nurses with a mean score of 14.6 chose choice 4. If such conclusion was not borne out by the further investigation, then choice 4 should be changed and the item not used in a bona fide examination until it had been re-investigated and shown to be validly discriminating.

- soma    1. the body  
          2. the soul  
          3. the earth  
          4. consciousness  
          5. the subconscious

The item "soma" (Table IV) is relatively difficult in that it was answered correctly by only 21.5 percent of the group. The difference between 16.8 and 12.0 is, however, large enough for the correlation of the item with the total score to be satisfactory. Items that are both difficult and satisfactorily reliable are constructed only rarely. A much higher percentage of an item constructor's easy items are reliable than of his difficult items. The explanation probably lies in the fact that ambiguous items cannot be easy; they must tend to be difficult. Ambiguous items cannot be reliable. Easy items cannot

tend toward ambiguity. They therefore tend to be reliable oftener than difficult items. An examination that is to arrange the higher scoring competitors in a satisfactory order of merit must, however, contain some of these more difficult but reliable items.

For another type of item (Table V) the instructions were as follows:

Items . . . . . have to do with reactions, signs, syndromes, and tests that physicians sometimes use as diagnostic aids or devices. Each item consists of the name of a diagnostic aid followed by the names of five diseases or bodily conditions. You are to find the number of the disease or bodily condition that is one of the diseases for which the physician may use the reaction, sign, syndrome, or test in making his diagnosis.

- polyuria test    1. spinal fluid  
                    2. renal inadequacy  
                    3. gastric contents  
                    4. secretion of pepsin  
                    5. secretion of bile

For still another type of item (Table VI) the instructions were as follows:

Questions . . . . . have to do with finding in a group of five words the word that is extraneous to the other four words. Each item consists of five words; four of them constitute a group, and the remaining word does not belong in this group. You are to find the number of the word that does not belong to the group formed by the other four words.

- 1—ganglion    2—nevus    3—neuron    4—  
medulla    5—neurosome

For another type of item, (Table VII) the instructions were as follows:

TABLE IV. RESPONSES MADE TO THE ITEM (soma)

	Choice No. 1 (correct)	Any incorrect response	Answer omitted	Choice No. 2	Choice No. 3	Choice No. 4	Choice No. 5
N	46	168	13	15	8	52	80
M	16.8	12.0	9.0	11.5	12.6	12.5	12.2

TABLE V. RESPONSES MADE TO THE ITEM (polyuria test)

	Choice No. 2 (correct)	Any incorrect response	Answer omitted	Choice No. 1	Choice No. 3	Choice No. 4	Choice No. 5	Two answers
N	187	27	4	7	1	4	10	1
M	13.6	8.6	8.2	6.6	14.0	7.8	9.2	17.0

TABLE VI. RESPONSES MADE TO THE ITEM (nexus)

	Choice No. 2 (correct)	Any incorrect response	Answer omitted	Choice No. 1	Choice No. 3	Choice No. 4	Choice No. 5
N	146	68	2	5	4	43	14
M	14.1	10.7	12.0	8.4	8.8	10.8	11.7

TABLE VII. RESPONSES MADE TO THE ITEM ("A" and "B")

	Choice 2-6 (correct)	Any incorrect response	Answer omitted	Choice									
				1-4	1-5	1-6	1-7	2-7	3-6	3-8	4-5	4-6	4-7
N	101	113	1	1	1	26	12	3	12	17	4	14	22
M	14.9	11.4	10.0	9.0	7.0	11.2	10.7	11.3	13.3	12.4	7.5	12.4	10.6

TABLE VIII. RESPONSES MADE TO THE ITEM (matching related words)

	B C A (correct)	Any incorrect response	Answer omitted	Choice ABC	Choice ACB	Choice BAC	Choice CAB	Choice CBA	Incorrectly formulated answers
N	164	50	1	9	8	20	3	6	3
M	14.1	9.6	5.0	7.9	11.9	9.8	6.3	10.8	9.7

Items . . . . . have to do with statements from each of which two sets of words or phrases have been omitted. The *first word or phrase omitted* can be found among the first *four key words or phrases*, numbered 1, 2, 3, or 4, and the last word or phrase omitted can be found among the *last four words or phrases*, numbered 5, 6, 7, or 8. You are to find the numbers of the *two words or phrases which best complete each definition*. Notice that the first figure of the answer is always smaller than the last.

The publication called (A) is prepared and published by (B).

## (A)

1. Appraisal Form for Local Health Work
2. Public Health Reports
3. The Child
4. American Journal of Public Health

## (B)

5. American Medical Association
6. U. S. Public Health Service
7. National Organization for Public Health Nursing
8. National Congress of Parents and Teachers

This item would have been a better

one if 12 nurses with a mean score of 13.3 had not indicated that *The Child* was prepared and published by the U. S. Public Health Service.

The instructions for another type of item (Table VIII) were as follows:

Items . . . . . inclusive have to do with matching or associating each of one set of words with each of a second set of words. In each item you are to find the word lettered A, B, or C that can be associated with or matched with each of the words numbered 1, 2, or 3.

1—typhoid fever

2—undulant fever

3—measles

A—filterable virus

B—bacillus

C—Brucella melitensis

The instructions for another type of item (Table IX) were as follows:

Items . . . . . have to do with the knowledge, principles, and general information usually considered as belonging to the field of public

TABLE IX. RESPONSES MADE TO THE ITEM (multiple choice)

	Choice No. 3 (correct)	Any incorrect response	Answer omitted	Choice No. 1	Choice No. 2	Choice No. 4	Choice No. 5
N	147	67	0	20	26	12	9
M	14.1	10.6	—	9.4	10.0	14.2	10.0

TABLE X. RESPONSES MADE TO THE ITEM (thrombosis)

	Choice No. 4 (correct)	Any incorrect response	Choice No. 1	Choice No. 2	Choice No. 3	Choice No. 5
N	197	17	5	11	0	1
M	13.0	13.2	12.6	13.3	—	15.0

health nursing. Each item consists of a premise or first part and five possible choices or answers which might complete the premise or first part.\* You are to find the choice which best completes the first part of the item. First, read very carefully the premise or first part of the item. Then, read each of the possible choices; compare each of the possible choices with the premise and with the other possible choices. Select the choice that best completes or best *answers* the first part of the item:

In the development of public health nursing service in the United States, one of the fundamental principles universally adhered to by both public and private employing agencies is:

1. to employ only nurses certified by the state health departments.
2. to adopt the "standing orders" for nursing care recommended by the National Organization for Public Health Nursing.
3. to secure medical authority for all nursing procedures.
4. to refer for advice on program to a representative committee of lay people.
5. to maintain a ratio of one supervisor to every eight to ten staff nurses.

Again we have an item that appears to be satisfactory when it is studied only from the point of view of correct or incorrect answers. If, however, attention is directed toward the mean scores of those choosing each incorrect choice, it is seen that 12 nurses with a mean score of 14.2 thought choice 4 was the correct answer. Thus the item should not be used in a bona fide examination until it had been shown that this occurrence was fortuitous or until choice 4 had been changed.

\*Most of the questions now being sent out by the Subcommittee on Merit Systems are of this type. It should be mentioned, however, that up to the present time such questions have not been pretested as in this preliminary investigation.

#### More poor items:

- thrombosis
1. stagnation of the blood
  2. inflammation of the intima of a blood vessel
  3. formation of fusiform, nucleated blood-cells
  4. formation or development of a clot
  5. a blood platelet

In the construction and review of this item (Table X) it was unfortunate that no one noticed how nearly correct choice 2 was. Thus the mean score of those choosing choice 2 was as high as that of those choosing choice 4, and the item had no reliability.

In this preliminary investigation, the vocabulary items were arranged alphabetically. In an actual examination we should have preferred arranging in an order of increasing difficulty. The result was that the item on *thrombosis* immediately preceded that on *thrombus*. This may have been unfortunate. We have no evidence as to how nurses would react to these items when not adjacent.

The following two poor items (Tables XI and XII) are indicative of the types of responses that are found when the information necessary to answer the items correctly is outside the experience of too many of the competitors. Neither of the next two items should be used in a bona fide examination.

- struma
1. hyatid mole
  2. the blood stream
  3. soma
  4. stroma
  5. goitre

Susceptibility to infection from hookworm is universal, but not distributed uniformly among population groups. In the southeastern area of the United States, various

TABLE XI. RESPONSES MADE TO THE ITEM (struma)

	Choice No. 5 (correct)	Any incorrect response	Answer omitted	Choice No. 1	Choice No. 2	Choice No. 3	Choice No. 4
N	6	208	35	75	58	5	35
M	12.0	13.0	11.3	13.6	13.6	9.4	13.1

TABLE XII. RESPONSES MADE TO THE ITEM (hookworm)

	Choice No. 1 (correct)	Any incorrect response	Answer omitted	Choice No. 2	Choice No. 3	Choice No. 4	Choice No. 5	Two answers
N	47	167	7	89	56	7	3	5
M	12.7	13.1	13.4	13.3	13.9	8.7	8.7	9.4

factors, including opportunity, influence the relative incidence of the clinical picture of hookworm. In which one of the following groups would the incidence be relatively greatest?

1. Children over four of low-income, rural, white families.
2. Children over four of low-income, rural, Negro families.
3. Young adults twenty to thirty, and either white or Negro, when allowance has been made for income, and rural or urban environment.
4. Negro adults over thirty of low-income and living in crowded tenements.
5. White adults over thirty of low-income and living in crowded tenements.

As an item constructor accumulates experience in the construction, review,

and trying-out of items, he begins to think that he has developed a set of rules for the construction of reliable items. He probably does increase his percentage of reliable items; nevertheless, he is wrong too often for him to wish to use items in a bona fide examination until they have been pretested and found satisfactory.

This is the second of three articles on the principles and construction of merit examinations for public health nurses. Originally announced as two articles, the length of the text has necessitated its publication in three issues of PUBLIC HEALTH NURSING. The first appeared in October. Dorothy Deming is collaborating in the preparation of public health nursing materials.

## THE AMERICAN JOURNAL OF NURSING FOR NOVEMBER

Treatment of War Injuries.....	Donald E. Dial, M.D.
Nursing Care of War Injuries.....	Sheila M. Dwyer, R.N.
I Was on Guam.....	Leona Jackson, R.N.
Scholarship and Loan Funds in Schools of Nursing	
Teaching Medical Asepsis.....	Elizabeth Wilcox, R.N.
Overcoming Mental Barriers.....	Ernestine Wiedenbach, R.N.
Scholarship and Loan Funds in Schools of Nursing.....	Margaret E. Conrad, R.N.
Your Federal Appropriation.....	Mary J. Dunn, R.N.
Recruitment on a College Campus.....	Eleanor Marie Helm, R.N.
What the War-time Baby Wears.....	Sarah Ward Gould, R.N.
Children with Problems.....	Margaret Bowen, R.N.
Help for the Newly Blind.....	Mary Dranga Campbell
Make Printed Matter Work for You.....	Sylvia Richards and Louise Aul, R.N.

# Public Health Nursing and Census Tracts

By DOROTHY W. MYERS AND NELLIE R. DILLON, R.N.

**T**HEY SHALL not die" in my census tract!

That's what the nurses in The Providence District Nursing Association are saying. That is why we believe that a cooperative piece of work in Providence, Rhode Island, between the Research Bureau of the Providence Council of Social Agencies and The Providence District Nursing Association has already resulted in better health and the saving of lives. This result has been accomplished by redistricting the Association; making one or more nurses responsible for nursing service in a small area of the city, a census tract; and analyzing service statistics in relation to the vital statistics for that tract each year. The nurse does the work in the field, the Research Bureau collects the statistics, and together the nurse and statistician study and analyze the results.

It started back in 1936 when the United States Bureau of the Census asked Providence to establish boundaries for small homogeneous areas with a population of between 3000 and 5000 in each. Forty-nine census tracts were laid out at that time. A committee of citizens familiar with the city approved the boundaries and the U. S. Census Bureau accepted them. The Research Bureau coded each address in Providence by census tract and published a street index by house number by census tract so that any list of addresses could be coded and tabulated. The Providence Council of Social Agencies appropriated the money to pay the Census Bureau for tabulating selected items from the 1930 population census, by census tracts.

These were the tools—the street index and the basic population data. One of

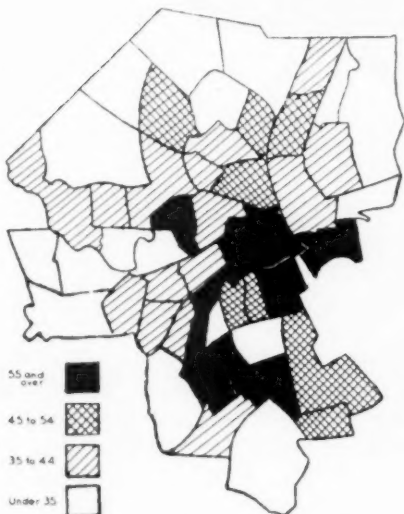
the first subjects studied was deaths from tuberculosis. The addresses were obtained from the City Health Department, which has been consistently helpful and cooperative, and each year from 1936 on, the tuberculosis death rate for that year has been computed by the Research Bureau for each census tract and the death rate per year (average for three-, four-, and five-year periods) has been computed as the data are available. The Providence District Nursing Association was instantly interested in the tables and maps and realized their importance. They had had five districts in the city, the boundaries of which had long since been established. Of course the boundaries of the nursing districts did not coincide with census tract boundaries, so that although census tract rates were of general interest to the agency, they could not be as pertinent as if each of the nursing districts included certain specified whole census tracts. It took time and thought and planning to change the district boundaries but in 1939 the Association revised them to coincide with census tract boundaries. Now each district includes a certain number of census tracts. That was the first step. Later a further step was taken and one or more nurses were assigned to each census tract within the district.

## INFANT MORTALITY STUDIED

In the meantime the Research Bureau was working on the problem of infant mortality. Since this rate is calculated on the base of 1000 live births, the address of every resident birth had to be coded as well as the addresses of the deaths, and the Research Bureau turned

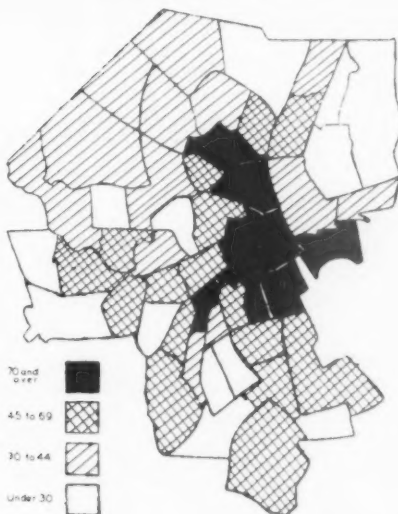


INFANT DEATHS PER 1000 LIVE BIRTHS,  
1936-1940, BY CENSUS TRACTS,  
PROVIDENCE, R. I.



City infant mortality rate, 1939—39.1 per 1000 live births

AVERAGE DEATHS FROM TUBERCULOSIS  
PER YEAR, PER 100,000 POPULATION,  
1935-1940, BY CENSUS TRACTS,  
PROVIDENCE, R. I.



City tuberculosis death rate, 1939—43 per 100,000 population

to the Volunteer Bureau for help. A volunteer was secured who each year for five years coded the addresses of over 3000 infants born to residents of Providence. The maps reproduced here show the infant mortality rates and tuberculosis death rates by census tracts.

Providence has prided itself, and with cause, on its low death rate from tuberculosis and its low infant mortality rate. But the rates by census tracts showed that certain areas in Providence had appallingly high death rates. The surprising thing was that the tracts with the highest infant deaths were not necessarily problem areas in other respects. Two of the census tracts with high infant mortality rates were areas with high rents and a population with more than average schooling. Another census tract which was in the lowest rent brackets, with a population having the least education, was in the group having the lowest infant mortality. High birth rate was not a determining factor since only three of the 12 tracts having the highest birth rate

were among the 12 highest infant mortality rates.

The next step was a comparison of American Public Health Association standards of service with the achievement in each district. With statistics available by census tracts, each district could be rated on its accomplishment. For tuberculosis service the American Public Health Association standard is five diagnosed cases (known to be living in the area) for each death. The percent of standard reached by the five districts varied from 55.8 to 140.4 percent. The American Public Health Association appraisal form sets a minimum standard of 30 visits a year to active cases for every death, and 12 visits a year to all types of tuberculosis cases for every active case carried by the nursing service. The figure for the Association as a whole was 37.2 visits per death, but the districts varied from 19.9 to 69.7 visits per death.

The Association as a whole made 16.1 visits to all types of tuberculosis cases

TABLE I  
TUBERCULOSIS SERVICE: COMPARISON OF STANDARDS WITH ACHIEVEMENT

District	Percent of A.P.H.A. standard (5 diagnosed cases for each death) reached	Number of visits per death	Number of visits per active case
Association, total	87.9	37.2	16.1
District 1	140.4	54.2	16.5
District 2	96.0	52.6	14.8
District 3	88.2	27.6	16.5
District 4	85.2	69.7	15.7
District 5	55.8	19.9	12.0

per active case carried. The district variation was from 12.0 to 16.5 visits per active case carried. (Table I.)

The same type of comparison was possible in the infant welfare service. With 67.7 percent of live births registered under nursing supervision, the Association as a whole was well above the A.P.H.A. case load standard for infants under one year of age, but one district was below the standard for that district's death rate, and one was far above the standard. The A.P.H.A. sets a standard of four visits a year for every infant

registered for nursing supervision. All of the districts were above this minimum but they varied from 4.7 to 6.9 visits.

As a result of the final analysis of rates and services by census tracts, district boundaries were again changed in order that available nursing service might be concentrated in the problem tracts. This meant cutting case loads in some of the districts and building them up in others. And most important, each nurse is conscious of the problems in her own census tract and district and interested in results of her efforts.

TABLE II  
INFANT WELFARE SERVICE: COMPARISON OF STANDARDS WITH ACHIEVEMENT

District	Number of infant deaths per 1000 live births	Percent of births under nursing supervision A.P.H.A. standard*	Achievement
Association total	39.1 (City)	50	67.7
District 4	52.7	65	82.8
District 3	52.0	65	59.8
District 5	46.5	50	58.0
District 1	40.8	50	61.5
District 2	37.4	50	76.6

\*30 percent of live births registered under nursing supervision where infant mortality for past 3 years is 30 or less; 50 percent with infant mortality 31-50; 65 percent with infant mortality 51-75; 80 percent with infant mortality 75 or over.



# Health and Safety of Employee--- Nurse's Viewpoint

By RISPAH PORTER, R.N.

Many small plants are trying out health programs as did this industrial nurse in the early days of her experience which she describes with high enthusiasm

**W**E WERE BUSY in the year of 1929. Business was booming and the present health and safety program in this large midwestern foundry, of which I was a part, had just begun. I had had no experience in industry and did not know just what was expected, nor did I know how much could be done. However, with the help of my hospital training and some previous work in a physician's office I soon developed a keen appreciation of the many ways in which a nurse can be of service to the industrial worker.

Due to the farsightedness of our personnel manager, safety activities began to shape themselves, although the nurse's duties in the beginning were largely limited to caring for injured men as they were reported to her. The prevention of infection is important as is also the directing of employees to the physician promptly. Using first aid as a starting point for my nursing program, I set out to find a solution to the problem of wound infections which were common at this time. Such complications are a reflection on the service of the nurse.

To become acquainted with the foremen and to know something of their attitude toward the nursing service seemed to be a first step in obtaining my objective. I proceeded to do just that. The older foremen who had grown up with this industry had frequently told me that a great deal of time had been

lost from work as a result of infections, but it was difficult to sell them the idea that something could be done about it. The younger men were more open to suggestions. Complimenting the men when they reported promptly helped further my efforts. I even cultivated them by discussing baseball, football, basketball, and their various hobbies. Later I learned from one of the supervisors that this procedure had worked magic—I had obtained the workers' confidence, hence they were sincerely interested in helping me with my problems. I was very proud of the fact that at the end of a short period I was able to show a tremendous decrease in complications brought about by infections.

## EMPLOYEE SAFETY PROGRAM

Selected employees from each plant met at regular intervals and made inspection trips with me through the factory. Recommendations made on the basis of their findings were carried out as promptly as possible. We learned that it was impossible to attain our objective without the complete support of every employee in our industry. We wanted each and every employee to feel that he was a member of the safety group. The various departments were then divided into groups under the leadership of one executive, and they selected their own group chairman and secretary.

Our employees believe in contests, which at present are based on costs per thousand man hours worked. A report is made up monthly on statistical information received from our insurance carrier. This report is sent to department heads and to the safety group chairmen. Various means are inaugurated to stimulate these contests. We have used white elephants called "Susies" which carry the inscription, "I am here because you have had a lost-time accident; if after 30 days I find you are again safety-minded, I will go away." The rivalry which the Susies caused was quite sensational.

While the safety program is definitely in charge of the safety director, it is important for the nurse to attend these safety meetings occasionally. An interest in safety is contagious, and when the nurse is vitally interested, she soon infects with enthusiasm the employees and others who work with her.

#### PHYSICAL EXAMINATIONS

Our physical examination program developed because of a real need. One of the occupational health hazards common to all foundries is silicosis.

Pre-employment physical examinations are in effect and for a number of years all our foundry workers were re-examined annually. However, re-examination is now considered unnecessary except upon the advice of the physician. Improved foundry conditions, cleaner and airier working surroundings and the lessening of dust through improved methods of cleaning have made the foundry a safe and healthful place in which to work. The employee is also protected through the use of respirators in very dusty occupations such as annealing, packing and dumping. Such workers are given regularly a complete physical examination which includes chest x-rays. Our physical examinations have uncovered several early cases of tuberculosis, all of whom sought sana-

torium care and have since returned to work. Care has been taken to place such workers properly and in safe surroundings and they are rechecked periodically.

#### CORRECTIVE PROGRAM

Efforts to secure the correction of defects revealed through physical examinations comprise an important part of the nurse's program. As a whole our employees respond well to suggestions for their physical betterment, and a great deal of time could be spent on this particular phase of the health program. When emphasis is placed upon the importance of these corrections at the time when the physical examination takes place, employees are more amenable to our suggestions for corrective work.

We spend a great deal of time on health education. This is not a separate function but is interwoven into our daily duties. Through the daily contacts with the workers, many abnormal conditions have been revealed—such as cancer, diabetes, heart disease—which brought to the attention of a physician early enough are responsive to treatment.

#### PROTECTIVE CLOTHING

No small part of the nurse's duties lies in the preventive work which she does. Protective clothing is essential to the worker's health and safety. The nurse needs to know that workers on drill presses must have their sleeves short or properly rolled, that they must not wear neckties, nor have long hair. You may ask, "Isn't that the duty of the safety engineer?" Yes, it is. However, it is also the duty of the nurse to work with the safety engineer to keep constantly before each employee the importance of his individual responsibility. For a period of about nine years safety clothing and protective devices were handled in the first aid department. This seemed expedient, as all new em-

ployees interviewed the nurse and were given goggles, safety shoes, gloves, et cetera. This had many advantages as the employee became better acquainted with the nurse and the nurse more familiar with the conditions under which the employee was expected to work. She had an opportunity, too, to stress the importance of these particular protective devices to the employee. With the growth of our company, this part of the safety program has become such an important one that steps have had to be taken to remove this feature of accident prevention to a separate department. It is now handled entirely by one full-time employee. Frequently employees are uncertain as to whether or not they have been given the proper equipment for their protection. They do not hesitate to ask the nurse and if she approves, they go on their way satisfied that all is well.

Now that so many industries must take on women employees in great numbers, it is more essential than ever that the nurse develop an awareness of this problem. She knows the woman's reactions toward proper clothing and can help the supervisor to use diplomacy to prevent resentment against the management.

#### NURSES' RECORDS

There can be no better means of evaluating a nurse's work than by means of well-kept records. Then, too, this is a splendid and practically the only way of keeping management informed of her activities. Management is accustomed

to dealing with facts. When these facts are presented in an orderly, intelligent fashion, they have merit. It is no small part of a nurse's duties constantly to sell the services of her department. She can do this, in part, through records. If costs have decreased through her activities, then this should be noted. Comparative records are important. Records protect the employer from false claims and they also protect the employee by giving him his just due. Our records are kept in such manner as to inform the heads of departments as to lost time sustained in each department. Accidents are classified by causes so that the safety committees and their members are informed as to where activity should be directed to curtail these losses. We have clerical assistance with our records.

We are now working on a plan whereby the entire findings of each employee will be on one card. This will include the results of the physical examination, record of accidents, reported illness, lost time due to illness and lost time caused by accidents, occupational or nonoccupational. We believe this will serve as a basis for research, which should eventually help to decrease losses from these causes.

Through the combined efforts of the nurse's department, the management, and the safety committees we hope to attain our goal—a minimum of accidents and illness.

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Presented before the N.O.P.H.N. Industrial Nursing Round Table, Biennial Convention, Chicago, Illinois, May 18, 1942.

**N**OT LONG ago our Subcommittee on Nursing told me of the case of a group of 17 retired nurses who took a refresher course to equip them for war-time service on the home front. But only two of that 17 went back to work. "We are ready," they said, "we will serve when the need is urgent—when the bombs begin to fall."

The need is urgent now. The emergency is here.

We have been bombed. Not by four-ton block-busters and incendiaries. We have been bombed by circumstances.

—PAUL V. McNUTT, *Chairman, War Manpower Commission.*



# Maintaining Education Standards Locally

By LONETA M. CAMPBELL, R.N.

The first of a number of Biennial papers on how standards for nursing preparation can be held steady in the face of necessary wartime change

THE PRESENT emergency with its demands on nursing of all types has brought to local public health nursing agencies the problem of meeting greatly increased community needs and at the same time maintaining standards of professional preparation which will insure a high quality of nursing care.

The Education Committee of the National Organization for Public Health Nursing has recently listed certain underlying principles which guided them in formulating the recommended qualifications for public health nurses. They were stated as follows: (1) One of the essentials in public health nursing is the ability to work effectively with people. (2) The public health nurse must be a competent nurse with sound basic theoretical and clinical preparation in nursing and with an understanding of its social and health aspects. (3) Additional study, including supervised field experience, is essential to prepare the graduate nurse for the specific functions of public health nursing. (4) Continued in-service education is necessary to further the development of the nurse's potentialities for improved service to the individual family and community, which is the goal of all public health nursing.

Keeping these principles in mind, I would like to tell you what our community has done to meet this challenge.

We have realized how much depends on the wise selection and handling of nurses appointed to our staff. In-

creasing consideration has been given to her personal qualifications,\* such as (1) emotional maturity and emotional stability (2) the quality of liking people and of interest in them and their needs, but possessing sufficient objectivity to see situations as they are (3) flexibility, which permits her to adapt to people and circumstances (4) imagination that enriches her work (5) resourcefulness in meeting new situations (6) tolerance that permits her acceptance of another's views even without agreement (7) ability to participate in community activities (8) the capacity to develop and be enriched by her experiences. These criteria have not been changed, nor need they be, although it may become increasingly difficult to find the nurse endowed with such personal attributes.

We have made no exception in our demand that nurses appointed to our staff must have had sound basic training and must be *good* nurses.

It has been increasingly difficult for us to obtain nurses with the postgraduate preparation in public health nursing, and we have had to make some changes in our requirements on this score. However, we do insist on the nurse's definitely planning to take postgraduate work at as early a date as possible and expect it will be completed within a five-year period.

While we find it hard to release nurses for study we continue to do so, allowing additional time coupled with the

\*Kauffman, Margaret and Malmud, Helen. Evaluations of Staff Members in Private Family Agencies. Family Welfare Association of America, 1940. 37 pp.

vacation period for summer study, and later a leave of absence for a full semester. We believe it important to encourage each staff member to take such courses at the local university as will further her professional preparation.

In taking new members on the staff, we have drawn on the students showing particular aptitude for public health nursing in their affiliation with us.

Over the past year, we have interested nurses not in active practice who have kept in touch with nursing, in taking a refresher series of classes and demonstrations to bring them up to date on the organization's policies, techniques, and problems. These nurses form a reserve upon which we can call for emergency service.

All of this effort to maintain educational standards as well as provide a high quality of nursing service has imposed greater responsibility on our supervisors as well as on the staff itself. Much assistance in recognizing and handling of social problems, many of them of the *pre* case work agency type, has been given by our supervisor who is a medical social worker. By adding a trained physiotherapist to our staff, we are attempting to improve the quality of our orthopedic service, as well as general staff nurses' understanding and treatment of these cases which we have every reason to believe may be greatly increased in the months ahead.

In planning our education program, we have given considerable thought to joint staff projects in which all the public health nurses in the city participate. Since Pearl Harbor the joint staffs took the advanced course in first aid in preparation for emergency service should an enemy attack occur locally.

Another example of interagency cooperation was the development of the community project on the care of the premature infant. Representatives from

each public health nursing agency developed uniform techniques for the home care of this immature baby, reconciling them with the hospital procedures through consultation with the supervisors in the pediatric divisions of the various hospitals, particularly those having the bulk of premature infants. As the community project was about to be launched, an all-day institute was held for doctors and nurses, hospital as well as public health, and lay groups. The public health nursing staffs jointly demonstrated the preparation of the home and the family for the return of the infant from the hospital. I have cited this case to show how we are attempting to avoid confusion and duplication in our teaching, both in content and method. This close cooperation is carried into many phases of our community public health program.

The sharing of special supervisors in a consultant capacity has also been given considerable thought.

We realize that we have made only a beginning in the adjustments which will be necessitated by this war emergency, but we are determined to maintain educational standards for our staff members just as far as it is possible for us to do so.

Quoting from a recent editorial by Hortense Hilbert: "To do the best we can to help maintain essential health services and health education; to help the families we serve keep up morale, by doing our part toward the relief of tensions; to give families an understanding of the use of community facilities for care during illness and for preventive health services—these are our continuing functions in war as in peace."\*

\*Hilbert, Hortense. "Public Health Nursing in Time of War." *PUBLIC HEALTH NURSING*, March 1942, p. 127.

## Reviews and Book Notes

### CARRY ON LONDON

By Ritchie Calder. 163 pp. The Musson Book Company, Ltd., Toronto, 1941. \$1.50.

It is difficult for Americans to grasp the reality of air attack upon the civilian population. This fact is one of the impedimenta in the development of a thorough-going and workable civilian defense mechanism.

Ritchie Calder has produced one of those rare books which gives a clear picture of the seemingly impossible situation which exists in a city under attack. He writes with a realism which should prove helpful to those concerning themselves with the solution of potentially similar problems in this country. The book is particularly significant in showing the spirit behind British civil defense which led to its unquestioned triumph in the Battle of Britain. Personalities such as Mickey the Marshall, "three feet six inches of reckless unconcern and tireless energy," will live in the memory as true heroes of this war. The spirit which led men and women to carry through exhausting and dangerous tasks merely "because they thought they ought to" is in sharp contrast to what we have been able to learn of the reactions of those living under dictatorial governments, under which people do what they are told and are in fear of doing more.

Mr. Calder's book will give comfort to those who are disturbed here by disheartening factors such as apathy, resistance to well-considered suggestions, local pride, incomplete planning, apparent confusion in high and low places. Many of the difficulties described by him have their counterpart here at the present time. It is comforting to know that human needs are successfully met in the end despite the complexities involved in the striving to

meet them. The book clearly demonstrates that the qualities of human sympathy and understanding are great forces that can and will triumph over red tape.

It should be clear that human wisdom is not great enough to foresee and provide for every eventuality of modern total war. *Carry On London* shows us that the gaps in planning which result from the limitations of human wisdom can be plugged by ingenuity which is allowed full play under the democratic system. Its importance lies in giving us a picture of what we may have to endure, and a basis for a renewed expectation of success in combating the destructive forces which may be unleashed against our civilian populations.

H. VAN ZILE HYDE, M.D.  
*New York, New York*

### THE ESSENTIALS OF OCCUPATIONAL DISEASES

By Jewett V. Reed, M.D., and A. K. Harcourt, M.D., 225 pp. Charles C. Thomas, Springfield, Illinois, 1941. \$4.50.

The authors have made an extensive study of occupational diseases and have analyzed the literature for expert opinions that have been published during the past few years. They have taken the essential facts that have been established to date and have codified them in practical form. The chapters cover Chemical Poisons, Physical Agents, Skin Lesions of Occupational Origin, Occupational Diseases of the Lungs, Malignant Disease Associated with Occupation, Occupational Diseases Due to Infections, and Functional Disturbances Associated with Occupation.

Industrial nurses will find this book a valuable reference. It is well indexed and includes a selected bibliography, classified by hazards.

EDWARD G. MEITER, PH.D.  
*Milwaukee, Wisconsin*

**PSYCHOLOGY APPLIED TO NURSING**

By Lawrence Augustus Averill, Ph.D., and Florence C. Kempl, R.N. 455 pp. W. B. Saunders Company, Philadelphia, second edition revised, 1942. \$2.50.

This textbook for student nurses gives a simple and clear discussion of psychological principles. The material in each chapter is adapted to the nurse in her relation to the patient.

The five major classifications covered are: The Regulation of Our Behavior, The Mechanisms Behind Our Behavior, The Relationship of Learning to Behavior, Behavior in Specific Life Periods, and Behavior as Related to the Emotional Life. New material in relation to mental and emotional factors in meeting the problems of adjustment has been added in this edition.

EVELYN C. NELSON, R.N.  
*Minneapolis, Minnesota*

**SEX GUIDANCE IN FAMILY LIFE  
EDUCATION**

By Frances Bruce Strain. 340 pp. The Macmillan Company, New York, 1942. \$2.25.

Mrs. Strain has made a significant addition to her list of well-known publications with this "guide to sex education in the schools." It is moreover a timely contribution, since "Love, marriage, and war are close associates."

Even a cursory glance through the chapters reveals their worth for teachers from kindergarten through senior high school. In place of the usual barren outline, there is a wealth of pertinent material justifying the belief that sex education is a way of life. The emphasis on community support for the program, on incidental teaching, on personality growth and development, on integration and coordination throughout the whole curriculum, and the recognition of the normalcy of sex interest in children of all ages will appeal to progressive teachers. The chapters on early school experiences and family relationships will be good reading for parents. Nurses and social workers

may profitably spend some time on the section devoted to the problems of the adolescent, and veterans in the field may find practical help in the final divisions concerned with teaching techniques, counselling, and personal qualifications. The wise use of this material, both in our homes and in our schools, and the acceptance of the author's practical and sympathetic ideology will hasten the day when of all our young people it may be said, "Their thoughts are clearer, their steps are surer, their loves are sweeter, their future homes hold greater promise of permanency and happiness."

EVANGELINE H. MORRIS, R.N.  
*Boston, Massachusetts*

**GINGER LEE: WAR NURSE**

By Dorothy Deming, R.N. 227 pp. Dodd, Mead & Company, New York, 1942. \$2.

The many readers who have followed the Penny Marsh adventure series will be particularly interested in this latest book. It depicts the life of a young graduate of the Yale School of Nursing whose practical work was more important to her than class work. Her nursing career is her life, and she is confronted with the problem so many young nurses meet today—whether to join the armed forces to serve her country or to remain in her present position as a general duty nurse.

Ginger Lee, upon advice from Penny Marsh, passes her physical examination, takes oath, and joins the Army Nurse Corps. Her experiences and excitement are endless. The military life, which is not as strict as she had thought, includes romance, nursing, and following maneuvers. At the same time she uses her public health knowledge to check an epidemic in the nearby village.

Through Ginger's decisions, many important questions will be answered for those in the nursing profession and for applicants to schools of nursing.

2ND LT. KATHRYN E. PORTZ  
*Fort Custer, Michigan*

## RECENT PUBLICATIONS AND CURRENT PERIODICALS

## GENERAL

**THE KENNY METHOD OF TREATMENT FOR INFANTILE PARALYSIS.** Wallace H. Cole, M.D., John F. Pohl, M.D., and Miland E. Knapp, M.D. Prepared under the auspices of the Committee on Education of The National Foundation for Infantile Paralysis, Inc., 120 Broadway, New York City. Publication No. 40. 47 pp. Free.

This is a concise though detailed description of the Kenny method of treatment for infantile paralysis in the acute stage. Although it is primarily for physicians and physical therapy technicians, it will be useful also to nurses in helping them to understand the basis for treatment.

**THE LIFE OF FLORENCE NIGHTINGALE.** Sir Edward Cook. The Macmillan Company, New York, 1942. 510 pp. \$4.50.

Nurses will welcome this comprehensive biography which has been reissued in one volume.

**TEACHING NURSES TO TEACH.** Ruth Freeman, R.N. *American Journal of Nursing*, April 1942. pp. 406-416. 35c a single copy.

Supervisors will find valuable suggestions in this article.

**NURSING IN DISEASES OF THE EYE, EAR, NOSE, AND THROAT.** Members of the staff of the Manhattan Eye, Ear and Throat Hospital, New York City. W. B. Saunders Company, Philadelphia, seventh edition revised 1942. 313 pp. \$2.50.

This revised edition includes newer treatments in the care of eye, ear, nose, and throat diseases. Nursing procedures and techniques for each disease are given in detail.

**DO YOU WANT TO BE A NURSE?** Dorothy Sutherland. Doubleday, Doran and Company, Inc., Garden City, 1942. \$2.

**HISTORY OF THE SCHOOL OF NURSING OF THE PRESBYTERIAN HOSPITAL, NEW YORK, 1892-1942.** Eleanor Lee, R.N. G. P. Putnam's Sons, New York, 1942. 286 pp. \$3.50.

Includes an interesting account of the beginning of visiting nursing and social service in the development of this nursing school.

**PSYCHOTHERAPY IN MEDICAL PRACTICE.** Maurice Levine, M.D. The Macmillan Company, New York, 1942. 320 pp. \$3.50.

This nontechnical book, written for the general practitioner in medicine, the medical specialist in fields other than psychiatry, and the

medical student, contains practical information regarding general principles of psychotherapy.

**THE STORY OF THE RED CROSS.** 19 pp. The American National Red Cross, Washington, D.C. ARC 626, revised April 1942. Free.

**NURSING HISTORY.** Minnie Goodnow, R.N. W. B. Saunders Company, Philadelphia, seventh edition revised 1942. \$3.

## HOUSING

**HOUSING YEARBOOK.** Coleman L. Woodbury and Edmond H. Hoben, editors. National Association of Housing Officials, Chicago, 1941. 405 pp. \$3.

**RECREATION AND HOUSING FOR WOMEN WAR WORKERS.** Mary V. Robinson. Women's Bureau, U. S. Department of Labor, Bulletin No. 190. Superintendent of Documents, Washington, D.C., 1942. 40 pp. 10c.

A helpful guide for communities in meeting problems of housing and recreation for women war workers.

## INDUSTRIAL

**THREE ARTICLES** of particular interest to industrial nurses published in the July 1942 issue of *The Medical Clinics of North America*, West Washington Square, Philadelphia. \$2 a single copy.

**The Measurement of Sickness Among Industrial Workers** by William M. Gafafer, D.Sc. p. 1105.

**Fatigue and War Production** by Robert H. Flinn, M.D. p. 1121.

**Methods Employed in the Appraisal and Control of Industrial Health Hazards** by J. J. Bloomfield. p. 1161.

## NUTRITION

**MODERN BREAD FROM THE VIEWPOINT OF NUTRITION.** Henry C. Sherman and Constance S. Pearson. The Macmillan Company, New York, 1942. \$1.75.

**VITAMINS FOR HEALTH.** Henry Borsook and William Huse. Public Affairs Pamphlet No. 69. Public Affairs Committee, New York, 1942. 32 pp. 10c.

Contains information on the necessary vitamin requirements for everyday use.

**VEGETABLES FOR VICTORY.** Prepared by the Division of Nutrition, Bureau of Maternal and Child Health, Pennsylvania Department of Health, in co-operation with the Philadel-



phia Child Health Society. Available through the Philadelphia Child Health Society, Room 609, 311 South Juniper Street, Philadelphia, 1942. 50c a set.

A series of eight colorful charts showing vitamin and mineral values of vegetables.

FOOD VALUES IN SHARES AND WEIGHTS. Clara Mae Taylor, Ph.D. The Macmillan Company, New York, 1942. \$1.50.

An excellent reference on nutritive values of everyday foods.

FAMILY NUTRITION. The Philadelphia Child Health Society, Philadelphia, 1942. 106 pp. Free.

A very helpful pamphlet on family nutrition needs and requirements.

#### WARTIME

MANUAL ON INDUSTRIAL HEALTH FOR DEFENSE. The Division of Health and Social Services, the Massachusetts Committee on Public Safety, Boston, 1942. 30 pp. Free.

A handbook prepared to assist local industrial hygiene committees to develop their industrial health programs.

VICTORY AIDE HANDBOOK. Welfare Division, Minnesota Office of Civilian Defense, St. Paul, 1942. 69 pp.

Information on state and local civilian defense councils and responsibilities of the Victory Aides.

VOLUNTEERS IN FAMILY SECURITY. The Office of Civilian Defense with the co-operation of The Office of Defense Health and Welfare Services, Washington, D.C., 1942. 15 pp.

A manual for volunteers in health and welfare services.

THE JUNIOR LEAGUE VOLUNTEER. Association of the Junior Leagues of America, Inc., The Waldorf-Astoria, New York, 1942. 32 pp. 15c.

Public health nurses and lay members of public health nursing agencies will find helpful information in this pamphlet, which has been re-edited. It covers principles of volunteer service and education in relation to wartime needs.

AMERICAN RED CROSS NURSING SERVICE. The American National Red Cross, Washington, D.C. ARC 703-B, 1942. 9 pp.

For use in recruitment of Red Cross nurses.

### Where Has It Been Done?

(Continued from page 601)

It is not easy to offer to comb one's staff for the very best workers—those with the most desirable personalities, full postgraduate education, and sufficient experience to be at their prime—and help them to recognize their obligation to tackle these difficult situations in the war boom areas.

Neither is it easy when nurses are scarce to urge that the most promising young workers take time out for the education which will make them ready for present positions of responsibility, and for the postwar rehabilitation nursing tasks throughout the world. It is not easy for public health nursing schools to add to their already full curricula courses in new problems of supervision and administration, in industrial nursing, even in foreign languages.

It is not easy to insist that a significant proportion of young graduates of schools of nursing be recruited into public health work when the general community vision, as well as much professional nursing vision, is focused on care of the sick in large and growing institutions. Neither is it easy to improve or expand field training experience to accommodate these recruits, particularly in the face of loss of experienced teachers and supervisors.

But who says that the renowned resourcefulness of public health nurses won't bridge these difficulties? Here is our chance at real statesmanship. The opportunity to share successes and failures through these pages may give others courage to try as well.

LEAH M. BLAISDELL, R.N.  
Editorial Consultant



Mary E. Shaw (right), editor, and Leah M. Blaisdell (left), editorial consultant, together with Ruth Houlton, general director, will serve as a working unit of three in the publication of *PUBLIC HEALTH NURSING* during the coming months

## NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

### FIELD SERVICE

**F**IELD SERVICE of the N.O.P.H.N. during October included participation in sessions of the annual convention of the American Public Health Association held in St. Louis, Missouri, by Ruth Houlton, Hortense Hilbert, Jessie L. Stevenson, and Mary M. Macdonald.

Miss Connor visited Saint Louis University in Missouri and the University of Colorado, Boulder, Colorado, between October 16 and 23 in connection with their programs of study in public health nursing.

Institutes in orthopedic nursing have been actively resumed—the October schedule for Miss Stevenson and Carmelita Calderwood having included Scranton, Pittsburgh, Erie, and York, Pennsylvania. In addition, Miss Steven-

son conducted institutes in Chicago and Springfield, Illinois, and she and Miss Macdonald also conducted an institute in St. Louis at the time of the A.P.H.A. convention.

In late September, Miss Macdonald spent three days in Elizabeth, New Jersey, at the Visiting Nurse Association, consulting on plans for infantile paralysis after-care. On October 3 she demonstrated orthopedic nursing, including the use of Kenny fomenta, at New York University as part of a series of lectures on orthopedic conditions.

Purcelle Peck represented the N.O.P.H.N. at the yearly meeting of the West Virginia State Nurses' Association held in Parkersburg on October 15 and 16.

Field visits in connection with the

N.O.P.H.N. Study of Needs and Resources for Care of the Sick in Their Homes were continued during September and October by Sybil Palmer Bellos and Ruth Fisher. Four communities in the northeast and southeast were visited.

On October 5, Dorothy E. Wiesner, statistician, gave a day's advisory service to the Visiting Nurse Association of Bridgeport, Inc., Bridgeport, Connecticut. On October 14, she spoke to the public health nurses of District 13 of the New York Counties Registered Nurses Association on the material used in the records room at the Biennial Convention and on the statistical use of records.

Visits of observation of nursing in industrial plants were made to Philadelphia, Boston, Buffalo, Detroit, Chicago, and Minneapolis by Mrs. Bethel McGrath, industrial nursing consultant.



Bosse B. Randle

#### SCHOOL CONSULTANT APPOINTED

MEMBERS OF the N.O.P.H.N., especially those whose work is in the school health field, will be pleased to learn that Bosse B. Randle has been added to the staff of the National Organization as school consultant. Miss Randle is director of the Division of Public Health Nursing of the Department of Health of Nassau County, Long Island, and we are grateful to this agency for sharing her with us. She will spend some time each week in the National office and will act as secretary of the School Nursing Section.

Miss Randle is a graduate of the Army School of Nursing. She received her baccalaureate degree from Teachers College, Columbia University. While at Columbia she participated in the Horace Mann Summer Demonstration School Health Service supervising the field experience of school nursing students.

Her beginning experience, first as a school teacher and later as a public health nurse, was in Jefferson County, Birmingham, Alabama. Since then she has held responsible positions, both in the school health and in the generalized public health nursing fields, in Cattaugus County and other areas in New York State and in Grand Rapids, Michigan. She came to the Department of Health of Nassau County in 1938. Its proximity to New York City makes possible our use of a portion of Miss Randle's time.

#### HONOR ROLL

If you have not already notified us that your agency is eligible for an Honor Roll Certificate, there is still time for it to be added provided you will let us know at once. Just drop a card in the mail box, telling us that all the nurses on your staff (one-nurse agencies too!) are enrolled in the N.O.P.H.N. We will

Photographs on pages 650 and 651 are by Bachrach.



*Photograph by Delar*

Public health nurses, and especially industrial nurses, will be glad to know that Mrs. Bethel J. McGrath, whose work on the industrial manual was announced in September, will also serve as industrial nursing consultant to the N.O.P.H.N.

send your Certificate immediately. We'll be watching the mails for that postcard!

#### **ALABAMA**

Lamar County Health Department,  
Vernon

#### **CALIFORNIA**

American Red Cross, Public Health  
Nursing Service, Petaluma

#### **COLORADO**

\*Rio Blanco County Health Department,  
Meeker

#### **CONNECTICUT**

\*Visiting Nurse Association, Waterbury

#### **FLORIDA**

Migratory Labor Health Association,  
West Palm Beach

#### **GEORGIA**

Pierce County Health Department, Black-  
shear

#### **ILLINOIS**

\*Moline Public Health Nursing Service,  
Moline  
Ottawa Township High School-Board of  
Education, Ottawa

#### **IOWA**

\*Sac County Public Health Nursing  
Service, Sac City

#### **LOUISIANA**

Calcasieu Parish Health Unit, Lake  
Charles

Caddo-Shreveport Health Unit, Shreve-  
port

#### **MAINE**

Cumberland County Public Health Asso-  
ciation, Portland

#### **MARYLAND**

Talbot County Health Department,  
Easton

#### **MASSACHUSETTS**

\*Metropolitan Life Insurance Nursing  
Service, Malden

#### **MICHIGAN**

\*North End Clinic, Detroit

#### **MINNESOTA**

Allegan County Health Department,  
Allegan  
American Red Cross, Duluth Chapter,  
Duluth  
Parochial Schools, Duluth  
Martin County Nursing Service, Fair-  
mont

International Falls Nursing Service, In-  
ternational Falls

\*Jackson County Nursing Service, Jack-  
son

Industrial Nurse Service, Federal Land  
Bank, Minneapolis

Industrial Nurse Service, General Mills,  
Minneapolis

N. W. Bell Telephone Company, Minne-  
apolis

*(Continued on advertising page 7)*

# NEWS

## MORE RECRUITS NEEDED

BY SEPTEMBER 1942, 36,000 new student nurses had entered schools of nursing, about two thirds of the 55,000 quota set for the school year ending June 1943. More intensive recruiting by state and local councils, by schools of nursing themselves, and by every individual nurse is urged by the Committee on Recruitment of Student Nurses. At the beginning of the fall term 812 nursing schools in 47 states had reported to the Committee the following facts and comments concerning current classes: they were admitting 22,926 students, could have admitted 4,697 more; only 180 were using federal funds for increased school facilities; 223 felt they could have increased student admissions, had scholarships for personal expenses been available; 561 had enough good applicants, 251 not enough. Also reported to the Committee by some 200 schools were probable reasons adversely influencing fall student registration—housing and class room space inadequate, competition with jobs in industry, insufficient or poor applicants, lack of qualified instructors, students' worry about personal finances, lack of clinical facilities for teaching larger classes.

## LAY NURSING PROJECT

TO ASSIST in meeting the dangerous and growing nursing shortage, Mrs. John L. Whitehurst, president of the General Federation of Women's Clubs, has announced a gigantic nursing project in which each of the Federation's 16,500 clubs with a total of over 2,000,000 members will participate. In cooperation with the American Red Cross and the National Nursing Council for War Service the program will include recruitment of young women for nursing preparation, efforts to return eligible but inactive

nurses to service, recruitment of nurses for part-time hospital service, and sponsorship of home nursing and nurses' aide classes. Another important aspect of the program will be the raising of considerable sums of money for student scholarships. To stimulate club members and others in promoting this ambitious program the Federation will offer war bonds and certificates for meritorious effort.

## BACK TO WORK

TO SMOKE even more "hidden nurses" out of their holes, *Goodhousekeeping* in cooperation with the National Nursing Council for War Service will carry a full page story in the December issue about the need for inactive nurses returning to service. A tear-off form at the bottom of the page will ask for name of nurse, address, the name of a hospital where she would be willing to serve. The Council will take the returned form, write the nurse, write the state and local nursing council, and write the hospital about her. It is hoped that this triple-barreled attack will bring many nurses back into service.

## HIGH-SCHOOL VICTORY CORPS

THE ORGANIZATION of High-School Victory Corps in the nation's 28,000 secondary schools is recommended in a plan worked out by a special Policy Committee with the endorsement of War, Navy, and Commerce Departments and the U.S. Office of Education. The plan will promote, besides physical fitness, occupational guidance, citizenship study, military drill, competence in science and mathematics, preflight aviation training, training for critical occupations in which there is manpower shortage, and training for home and community service.

School nurses will be especially interested in points to be stressed in the



physical fitness program which besides a program of appropriate physical activities will include for every boy and girl periodic health examinations, correction of remediable physical defects, nutrition schedules, safety education, first aid, and knowledge of personal, community, industrial, and military hygiene. In this program the school must solicit all the aid and cooperation which various health agencies of the local community can muster.

Other details are contained in "High-School Victory Corps" (Victory Corps series, No. 1) which can be obtained from the Superintendent of Documents, Washington, D.C.

#### CHILDREN IN WARTIME

FOUR MUSTS comprise "A Children's Charter in Wartime" recently issued by the Children's Bureau Commission on Children in Wartime: (1) Guard children from injury in danger zones (2) Protect children from neglect, exploitation, and undue strain in defense areas (3) Strengthen the home life of children whose parents are mobilized for war or war production (4) Conserve, equip, and free children of every race and creed to take their part in democracy. In the more detailed explanation under each heading, health is given a main emphasis with some suggestions as to how community facilities should be developed to secure good health.

On August 28, the Commission, on which the N.O.P.H.N. is represented, discussed plans for coordination of approach to the particular problems of children in wartime on a state and local level, also the Bill now pending in Congress to secure money for special activities in relation to children in wartime. A statement concerning state and local planning with suggestions as to how agencies can participate individually and through such organizations as Civilian Defense Councils and the White House

Conference will shortly be available for general use.

A full copy of "A Children's Charter in Wartime" may be obtained from the Superintendent of Documents, Washington, D.C., by sending 5 cents.

#### HELP CIVILIAN DEFENSE COUNCILS

IN AN APPEAL to national agencies to urge their members to volunteer their services to defense councils where they live, Jonathan Daniels, assistant director in charge of civilian mobilization of the Office of Civilian Defense, writes:

You can contribute the influence of your organization to up-building the American community for complete mobilization during the war and for the peace that will follow the war. . . . The character of defense councils is the best measure not only of the security of people in their homes, but also a measure of the strength which all American towns can add together to the national war effort. Defense councils harboring improper politics, limited participation, and the domination of one class or group may hinder the successful prosecution of the war. . . . On the other hand . . . if defense councils are the instruments they were designed to be and can be, communities everywhere will meet the demands of the emergency and release productive power with cumulative and overwhelming results.

Countless public health nurses and nursing agencies are contributing to the war effort through local nursing councils and in other ways. Since local nursing councils are the most effective means of co-ordinating nurse power for military and civilian protection, nurses in communities which have not yet organized are urged to do so without delay. Both through nursing councils and as individual nurses they can add greatly to the effective operation of civilian defense councils. Especially can they recruit and direct lay volunteer helpers for public health nursing itself. As frequently reported this source of aid in the face of nurse shortage has hardly been tapped. If nurses contribute their numbers and their professional experience

to the work of local defense councils it may well result in more and improved volunteer service, and a community better prepared for dangerous days ahead.

#### HOMES IN TRAILERS

**A** SUGGESTED Ordinance for the Regulation of Trailer Coach Parking and Trailer Parks has been issued by the Office of Price Administration and Civilian Supply, Washington, D. C., as a guide to "new defense communities and other areas congested by defense activities" where trailers are used extensively for homes because of inadequate housing facilities and where there is no ordinance or an inadequate ordinance governing trailer parks. The ordinance "is designed to lay down minimum standards for the safety, health, and convenience of trailer families, and for the protection of the community."

~ ~ ~

- Ruth Harrington, assistant professor, University of Minnesota School of Nursing, will serve as professional secretary of the N.L.N.E. Committee on Educational Problems in Wartime. With other members of the staff at 1790 Broadway she will be available for consultation on problems of schools of nursing.

- Lieutenant Colonel Elizabeth L. Smellie, Matron-in-Chief of the Royal Canadian Army Medical Corps Nursing Service, visited Washington, D.C., September 13-17 at the invitation of the War Department. During her stay Miss Smellie discussed with officials of federal nursing services the organization and work of Canadian nurses serving the armed forces.

- Red Cross public health nurses have recently been assigned to areas near Army and Navy posts where unbeliev-

ably overcrowded living conditions present extra health hazards. Such nurses are now stationed in Pulaski County, Missouri, near Fort Leonard Wood; Lawton, Oklahoma, near Fort Sill; Brownwood, Texas, near Camp Bowie; and Onslow County, North Carolina, near the New River Marine Base. They are giving bedside care and instruction in Red Cross Home Nursing.

- On September 15 Emma E. Roberts resigned as director of The Toledo District Nurse Association. During 29 years of service Miss Roberts developed the Association to its present high professional standing, and gave tirelessly of time and ability to other health and welfare activities in the city of Toledo. In June of this year the University of Toledo conferred upon Miss Roberts the honorary degree of Master of Science. In 1934 she became the first life member of the N.O.P.H.N.

Mary M. James, formerly assistant director, succeeds Miss Roberts as director. Miss James is a graduate of Asbury Hospital, Minneapolis, Minnesota, with a Bachelor of Science in public health nursing from the University of Minnesota. Alice F. Malcolm now becomes assistant director.

- A "Symposium on Industrial Nursing" presented by the Greater Boston Branch of New England Division American Association of Industrial Nurses offers to nurses interested in the various phases of industrial nursing, a widely varied lecture program including such topics as setup of an industrial medical department, legal aspects of industrial nursing, nutrition, tuberculosis, occupational disease, mental hygiene, and many other industrial nursing problems. Classes began on September 28, and will continue on successive Monday evenings until December 21. For the opening lecture 110 graduate nurses registered.

• Translation of the American Red Cross First Aid Textbook into Spanish and Portuguese has been approved by the American Red Cross. The Spanish version will be prepared by the Monterey Chapter, Mexican Red Cross; the Portuguese, by the Brazilian Red Cross. These editions will be widely distributed through Central and South America, and profits from their sale will go to the Red Cross societies of the countries in which they are published.

• "Education for Free Men" is the general theme for American Education Week to be observed November 8 to 14. The sponsors are the National Education Association, the American Legion, the U. S. Office of Education, the National Congress of Parents and Teachers. The object is to inform people about what the schools are doing in the war effort, and how 27 million boys and girls are being prepared for the world to come. Of the special topics to be emphasized each day of the week, "Building Strong Bodies" scheduled for Tuesday, November 10 is perhaps of greatest interest for school nurses. Further information and helpful materials may be secured direct from the N.E.A., 1201 Sixteenth Street, N.W., Washington, D.C.

• With the stirring slogan, "Social Hygiene Takes Battle Stations," February 3, 1943, is designated as Social Hygiene Day by the American Social Hygiene Association. Send for information.

• The U. S. Civil Service Commission has notified us that positions of public health nurse, junior public health nurse, and graduate nurse, general staff duty, are still open, since not enough applications have been received to date. They point out also that in the original news release of the examinations (No. 240 and No. 242), the statement that graduation from high school is no longer required was in error—inasmuch as the requirements for public health nurse cannot be met without the completion of high school education.

• The Board of Civil Service Commissioners of Los Angeles announces unassembled examinations for the position of public health nurse with a monthly salary range of \$135 to \$150. The local residence requirement has been waived, and applications (which must be accompanied by a fee of \$1.00) may be filed until further notice. Application forms may be obtained from the Board, Room 11, City Hall, Los Angeles, California.

• The Indiana State Personnel Division announces unassembled examinations for the positions of public health nurse consultant and public health nursing director, with monthly salary ranges of \$200 to \$250 and \$250 to \$300. Applications may be filed until further notice. Forms may be obtained from the State Personnel Division, 141 South Meridian Street, Indianapolis.

#### NEW APPOINTMENTS

(See also *N.P.S. appointments*, page 608)

Mrs. Evans G. Richards has been appointed full-time executive secretary of the Utah State Nursing Council for War Service and state nurse-deputy to the state chief of Emergency Medical Service.

Mary D. Burr has been appointed executive secretary of the New York City Nursing Council for War Service, Inc.

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(*N.P.S. Continued from page 608*)

Doris E. Roberts, senior staff nurse, Neighborhood Association, Millburn, N. J.

\*Rachel Blain, health unit staff, Illinois State Department of Public Health, Springfield, Ill.

\*Mary Lee Brown, public health nurse (negro), Calhoun County Health Department, Marshall, Mich.

\*Mrs. Mabel T. Norton, staff nurse, Visiting Nurses of San Diego, San Diego, Calif.

#### ASSISTED PLACEMENTS

\*Ann M. Hellner, associate professor of public health nursing and associate director of school of nursing, Boulder division, University of Colorado, Denver, Colo.

\*Kathryn E. Worrell, assistant professor of public health nursing and field supervisor, University of California, Los Angeles, Calif.

Annette A. Bouffard, staff nurse, Wallingford Community Nursing Service, Wallingford, Conn.

# PUBLIC HEALTH NURSING

*Official Organ of the National Organization for Public Health Nursing, Inc.*

## CHRISTMAS GREETINGS



NINETEEN  
FORTY-TWO



**H**OWEVER strange our surroundings, however grave our responsibilities, Christmas of 1942 will find all of us with the same prayer in our hearts of "Peace on Earth, Good Will to Men." Public health workers have always exemplified the spirit of this prayer for their daily tasks are humbly, unselfishly and inconspicuously performed for the good of others, all ages, all races, all faiths. The beneficiaries of their labors are often unaware of them, perhaps even ignorant of their purpose and value, yet civilized countries have now come to expect and demand good health for their citizens. Encouraged by these results and with infinite faith in humanity and divine leadership, we press on to our tasks of helping all people become Men of Good Will who will bring to this Earth Peace for All People. God help us every one as we strive to answer our prayer!

MARION G. HOWELL, PRESIDENT  
NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

### A Chief Public Health Nursing Aim

**A**LMOST DAILY newspapers, magazines, and even radio commentators are reporting overcrowded conditions in hospitals throughout the country. Typical of such comment is the following item quoted in *The Journal of the American Medical Association* for October 24:

The increased number of obstetric cases which have crowded Washington hospitals, already overburdened by the wartime increase in population, has reached such proportions that hospitals are urging mothers to return home with their newborn babies, sometimes within one day after birth, to vacate beds for more cases.

This situation, together with the growing shortage of physicians and private duty nurses, makes it more than ever important that nursing care of the sick in their homes be made available to every family as a part of the public health program in every community.

Health officers are well aware of this need as evidenced by the fact that the Committee on Health Programs at the Washington Conference of the State and Territorial Health Officers passed a resolution in March 1942 urging that such nursing services be developed where they do not now exist.\*

The American Public Health Association unanimously adopted a similar resolution in October:

WHEREAS, the dislocation of considerable segments of the population and the dislocation of physicians, nurses, and dentists emphasizes the desirability of extending nursing care to the sick in their homes, and

WHEREAS, the accomplishment of this objective in many areas may now be possible through the coordination of all public health nursing services, including the full utilization of auxiliary services, therefore be it

RESOLVED, that the American Public Health  
(Continued on page 684)

\*Peck, Purcelle. "New Needs for the Public Health Nurse." PUBLIC HEALTH NURSING, June 1942, p. 291.

### N.O.P.H.N. Studies Bedside Nursing

**S**TARTLING INADEQUACIES in nursing care of the sick in their homes is the main finding in N.O.P.H.N.'s still-continuing study of home nursing in 16 communities. The purpose of the study is to measure the needs for home nursing services and to suggest patterns for public health nursing organization and administration which will make it possible for these and similar communities to meet them.

A preview of present resources in 13 of the total 16 communities to be covered follows:

In one of the 13 cities, towns, and counties there is no nursing care of the sick whatsoever by public health nurses. In 12, nursing care of the sick is provided only to policyholders in one or both of two insurance companies. In one of the 12, township welfare authorities also provide care to their clients as needed; in another, a "city nurse" gives nursing service to the sick in the homes of those who can, as well as those who cannot, pay for it—collecting fees from the former.

Eight of the 13 communities are characterized by rapid changes in population due to extensive war industries or military activities. These are located in various parts of the country and range in population from 15,000 to 120,000. Practically all are striking examples of inadequacy of resources for community nursing service at a time when medical personnel is greatly depleted and hospital facilities are sorely overtaxed. Even if the present resources of these communities were thoroughly coordinated, and the best and fullest use were made of all of the public health nurses now employed supplemented by the services of auxiliary workers, they still could not be stretched to include nursing care of the sick. Our sampling has revealed that the ratios of public health nurses to population in 7 of the 8 communities just mentioned as war activity centers range all the way from one public health nurse in 5,700 population to one in 15,000. This is exclusive of nurses employed only for services in industrial plants. A present commonly-accepted standard calls for a ratio of one in 2,000 to 2,500 for effective service. When industrial nurses are included in the count, 5 of the 8 communities still have only one public health nurse to 5,700 or more people.

(Continued on page 684)



# Maintaining Minimum Public Health Nursing in Wartime

PREPARED BY THE

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

THE CLASSIFICATIONS outlined by the National Nursing Council for War Service in the leaflet, "Priorities for Nurses,"\* indicate certain groups of public health nurses who should serve at home. These are public health nurses in administrative, supervisory, and teaching positions, and staff and industrial nurses essential for maintaining *minimum health services* in a given community.

Suggestions are here offered as a guide for local use in determining how essential public health nursing services can be maintained on the home front through modifications in community organization and agency administration.

## I. Community Organization

The coordination of community public health nursing services under the administration of not more than one official and one nonofficial agency has for some time been recognized as desirable for economy, efficiency, and quality of service. Long known to be desirable, such coordination now becomes imperative when conservation of public health nursing personnel is of utmost importance. Communities can no longer afford the slightest extravagance in the use of public health nurses. Any duplication in service or in administrative structure must be regarded as a serious extravagance.

Every community will wish to make an analysis of its public health nursing requirements—an analysis in which all agencies administering public health nursing will participate. The local nursing council for war service is the logical group to initiate such an analysis, both because of its obligation to community health and its responsibility for advising individual nurses in regard to where they can best serve. Following this, all possibilities for coordination of services which will ensure the most economical use of public health nursing personnel should be considered. Coordination may take one of several forms.

A merger of the voluntary agencies providing public health nursing or agreements between voluntary and official agencies whereby certain or all types of personnel and facilities are pooled or interchanged will come into consideration. Or, in smaller communities, it may be feasible to join the voluntary and official agencies. In such cases, a single governing body representative of the individual agencies and including wider representation as well would need to be established.

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\*Revision of "Nurses to the Colors!"

Whatever plan is decided upon as a permanent or transitional step, certain measures need to be adopted as soon as possible in every community. The total amount of public health nursing available in a community should be distributed on the basis of priority of need, without regard to former special agency objectives, interests, or sources of income. This means:

1. *Pooling all public health nursing administrators, supervisors, and instructors, and distributing their services* over the total number of public health nurses giving direct service and over auxiliary workers. It is particularly important in wartime to maintain an adequate supervisory and teaching staff because of the larger proportion of auxiliary workers and less experienced field nurses.

2. *Pooling all field nurses giving direct service, and assigning each of them for general service in a given district.* As a first step toward economy of personnel, direct services by a variety of specialized public health nurses should be eliminated.

3. *Preparing all public health nurses,* regardless of former agency affiliation or special type of service through refresher courses for giving general service including care of the sick and the injured.

4. *Mobilization and utilization of non-public health nursing personnel* for all functions that do not absolutely require public health nursing training and experience, and which can be performed under supervision of public health nurses. Both nursing and non-nursing, paid and volunteer auxiliary personnel, need to be considered. The value of these workers depends greatly upon the provisions made for their in-service training and supervision. Augmenting of clerical staff is also important.

As more of the chronically and acutely ill are cared for in their homes, as more hospital patients return to their homes at a time when intensive nursing care is still needed, as more deliveries take place in the home—our generally accepted peacetime standards in regard to the ratio of public health nurses to population are obviously none too high if the necessary preventive and health educational services are to be continued. However, during wartime, peacetime standards can neither be attained nor retained. As many as possible public health nurses must be released for military service or to other needy communities. The services of these public health nurses who remain must be spread not only through the use of economies in organization, but also by the use of numerous supplementary workers.

From limited experience, certain public health nursing agencies have found that a ratio of one full-time auxiliary worker to one public health nurse is practicable at the present time. This ratio takes into account some clerical duties by auxiliary workers.

A variety of population characteristics in the community and factors within the agency, as well as the kind and amount of training of the auxiliary workers, would naturally influence this ratio.

## II. Agency Administration

Certain administrative practices apply to all kinds of agencies that ad-

minister public health nursing. Agencies in different parts of the country report these modifications or new emphases now being introduced or considered:

1. *Generalization of direct service.* For the duration of the war, agreements might well be reached among all public health nursing agencies that the direct services of every field nurse in the community will be general.

2. *In-service education.* Every public health nursing agency will participate in joint plans for refresher courses, and will share responsibility for conducting them. For instance, the visiting nurse association could assume responsibility for teaching care of the sick and other bedside care in the home, whereas the department of health would be responsible for teaching control of communicable disease. It is especially important during wartime for every public health nursing agency to provide for continuous supervision and education of the staff, because the better prepared and more experienced staff nurses will have more responsibility for the supervision of the less experienced staff nurses and auxiliary workers. For this, they will need to be prepared on the job.

3. *Decentralization or centralization.* Serious thought is being given to what is most economical in the way of centralization of administration and service. In some large urban communities setting up branch offices or substations for less than 8 or 10 nurses has proved uneconomical because of the added cost of maintenance. In more rural communities where fewer public health nurses are employed but where transportation is a significant factor, greater decentralization is being considered.

The more uses to which a branch or substation is put, the greater the economy. Medical clinics, nursing conferences, group instruction, supervision and in-service training of regular and supplementary staff, and services to individuals to reduce the number of home visits, are all activities that can be conducted in branch offices or substations. The number of times that nurses report to their offices can be reduced for economy.

4. *Auxiliary personnel.* Public health nursing agencies everywhere are concerned with the mobilization and utilization of non-public health nursing personnel for services which need not be given by public health nurses, but which can be given in conjunction with and under the supervision of public health nurses. Assignment of auxiliary workers, whether paid or volunteer, nurses or non-nurses, to any particular group—either according to diagnostic, economic, or other status—should be avoided. Cases should be assigned only on the basis of the particular condition of the patient, or the particular situation in the home.

5. *Selection of cases.* When economy of public health nursing has to be practiced as rigidly as it does during wartime, selection of cases is necessary. The amount and kind of service given must be determined solely on the basis of individual need. Points at which selection should be considered are:

First, when the individual is referred for or seeks care. When it has been customary to assign a nurse for intake, consideration should be given to having this function performed by a clerk or auxiliary worker. The worker who serves in this capacity needs to secure the most pertinent information, must know the policies of the agency, and must know community health resources.

Second, when planning continuation of care. Cases under care should be reviewed periodically from the point of view of medical and nursing care, particularly long-term cases, such as tuberculosis contacts, latent syphilis, and various chronic conditions.

6. *Group service and instruction.* Group service and instruction should be substituted for individual service wherever possible. Group instruction and demonstration can be given in such services or conditions as tuberculosis, maternity, child care, home nursing and care of the sick, diabetes, heart disease, and rheumatic fever. Group education can also be directed to those responsible for care of children in day centers or foster homes, and to industrial workers. Certain kinds of treatments can be given to several persons at centers at specified times instead of to individuals by means of separate home visits.

7. *Delegation of responsibility.* Public health nurses will, of necessity, have to devote themselves more and more to teaching and supervising care given by others. Members of the family, relatives, neighbors, and friends will, under the supervision of qualified public health nurses, be prepared to perform many functions hitherto performed by professional nurses. Although this has long been considered desirable, this delegation of responsibility has not been put into practice as widely as necessity now demands.

8. *Review of medical policies.* At reasonably frequent intervals, there should be a thoughtful review of medical policies, standing orders, and outlines of work, with the medical advisory group. Public health nursing procedures should be brought into conformity with the most progressive medical and public health practice. In some communities, because of shortages of medical personnel, standing orders need to be enlarged and extended when it becomes necessary for public health nurses to give certain types of care, treatment, and instructions, which were formerly given by physicians.

9. *Records and reports.* Time and effort of public health nurses can be saved through simplification of recording and reporting, elimination of non-essential record items, avoidance of duplication of information, and streamlining of report and record systems. Many activities connected with the keeping and filing of records and reports can be delegated to clerical or auxiliary personnel. Uniformity of public health nursing records and reports throughout the community will prevent duplications, delays, and confusions.

It should be added that although it is considered unlikely that any

(Continued on page 677)

# Diseases in Warm Climates

By ERNEST CARROLL FAUST, Ph.D.

**D**ISEASES in warm climates are intrinsically little different from those in temperate zones. However, environmental conditions in the Tropics and the Subtropics affect both the propagation of the etiologic agents of disease and the susceptibility of human beings to infection, so that both in prevalence and in intensity, diseases in these areas fulminate to an extent rarely experienced in cooler climates.

Technically, the Tropics are the areas on both sides of the equator in which the mean yearly temperature is never less than 68° F., while the Subtropics are the zones on land and water bordering the Tropics in which the mean temperature for the coldest month of the year does not fall below 68° F. Within the area between the Tropic of Cancer in the Northern Hemisphere and the Tropic of Capricorn in the Southern Hemisphere, divergence of the isothermal border lines between the Tropics and Subtropics is due to the influences of air and water currents, of land and water masses, and to mountain ranges. Islands in warm climates usually have an equitable climate, with night and day temperatures close to 80° F. Centers of large land areas are usually hot swamp or desert, depending on the prevailing moisture. Nevertheless, high elevations in the Tropics are frequently as cool as alpine areas in temperate zones.

In the Western Hemisphere practically all of the southern half of the United States lies in the Subtropics, as do Central Argentina and Uruguay. All of the vast intermediate land areas, except for the highlands, have a tropical climate.

The sustained warmth and the prevailing moisture of warm climates pro-

vide ideal conditions for the rapid propagation of pathogenic microorganisms. This is particularly true of pathogens of the digestive tract and those which require insects and their allies as intermediate hosts. Moreover, the lack of stimulus for human beings in warm climates, coupled with the difficulties in heat loss from the human body under environmental conditions of tropical moisture, as well as reduced exercise and dietary indiscretions, all lower the threshold of resistance to potential disease-producers. Finally, the personal and group hygiene of native peoples in warm climates is notoriously poor, so that a vicious cycle of disease is readily set up. These factors provide the background for the existence of highly endemic disease areas and allow epidemics to develop almost overnight.

## DISEASES IN WARM CLIMATES

Diseases which are especially prevalent in warm climates may conveniently be divided into the following categories:

1. Those due to physical injury
2. Those of metabolic origin
3. Those due to venenation
4. Those produced by pathogenic microorganisms

### *Diseases due to physical injury*

As a result of lowered resistance to shock and to the invasion of pathogenic bacteria, bodily injury caused by gunshot wounds or by machete knives or due to fracture from falls has a much less favorable prognosis than it would ordinarily have in cooler climates.

### *Diseases of metabolic origin*

On the whole, metabolic diseases, as those of the cardiorenal organs, are much less prevalent among natives in the



Tropics than in cooler climates. On the other hand, the almost universal prevalence of malnutrition of severe clinical grade in the populations of warm countries conditions practically every act and outlook of these peoples. From birth the average person is handicapped by lack of proper elements in his diet. He develops anemia, rickets, sprue, pellagra, beriberi, or other deficiency diseases. These in turn lead to digestive disorders, cardiac disease, nephritis, and endocrine dysfunction. It must be remembered that with such a physical background natives in warm climates are peculiarly susceptible to infectious diseases.

#### *Diseases due to venenation*

The introduction of venoms and toxins into the human skin by scorpions, spiders, ticks, and snakes is much more important in the Tropics than in cooler climates, because these pests are not only more prevalent and of greater number and variety, but usually have more potent venom.

#### *Diseases produced by pathogenic microorganisms*

These diseases are almost legion and include infections acquired from unclean food and drink, those in which the pathogens actively enter the skin or are introduced into or onto the skin by transmitting insects or their kin, those which are due to direct skin contact with infected individuals or their clothing, those which invade the respiratory tract, and those which are transferred by sexual intercourse. The diseases in this group which are especially important in the Tropics are: amebiasis, bacillary dysentery, typhoid fever, and cholera; malaria, yellow fever, dengue, typhus fever, relapsing fever, plague, kala-azar, and African sleeping sickness; hookworm disease, filariasis, and blood-fluke infections; leprosy, syphilis, and yaws; dermatomycoses, and arthropod infestations of the skin; pneumonia, influenza, and tuberculosis.

It will be impossible to give detailed

consideration to all of the disease-producing entities so common in warm climates, but selected examples will be used. Particular attention will be placed on pathogenic organisms which gain entry to the body by the mouth and skin routes.

#### AMEBIC DYSENTERY

While clinical dysentery due to an acute infection with the pathogenic ameba, *Endamoeba histolytica*, is by no means rare in natives in the Tropics, the average native is relatively tolerant of this infection and usually has no dramatic manifestations. He is frequently referred to as a "carrier," although he possibly may have mild atypical symptoms, including a generally tired feeling, nervousness, lack of appetite, and loss of weight. In many tropical countries, surveys have demonstrated that a high percentage of the population harbors this organism. Even in the United States from 5 to 20 or more percent of representative groups surveyed has been found infected, although only a small proportion of these is manifestly ill.\* However, persons new to an endemic area of amebiasis, as North Americans traveling, prospecting, or carrying on business in the Tropics, almost invariably develop severe amebic dysentery when they depend on native food and drink.

In this connection, a very good rule to keep in mind in the case of all enteric diseases is the safeguard of thoroughly cooking all food, especially raw salad vegetables, and of boiling all drinking water. While chlorination of water is satisfactory for killing the bacilli of dysentery, typhoid, and paratyphoid infections, as well as cholera vibrios, it does not guarantee the nonviability of the cysts of *E. histolytica*, which constitute this pathogen's common state to which man is exposed. Fortunately

\*Faust, Ernest Carroll. "The Prevalence of Amebiasis in the Western Hemisphere." *The American Journal of Tropical Medicine*, January 1942, p. 93.

there are several safe, moderately specific anti-amebic drugs, such as chiniofon, vioform, and diodoquin, among the iodo compounds, and the arsenical carbarsone. Every person with dysenteric symptoms and others with vaguer intestinal difficulties should have the benefit of specific differential laboratory diagnosis, and if found to harbor *E. histolytica*, should be treated by a physician with one of these drugs until he is free of the infection.

Special attention should be given to guarding against infection with *E. histolytica* during vacation periods outside of well-sanitated urban communities, not only in Tropical America but in the United States as well. Water from rural wells may be contaminated from surface drainage containing viable cysts of the pathogenic ameba as well as bacillary, typhoid fever, and possibly infantile paralysis organisms. Moreover, it has been demonstrated recently by carefully controlled experiments carried out by Dr. Alan C. Pipkin in the writer's laboratory that common domestic filth flies can feed on human dung-containing cysts of *E. histolytica* and several hours later deposit these cysts in a viable state in their dejecta. Since flies are especially prevalent in rural communities in the summertime, campaigns to control their breeding are essential if they are to be eliminated as a source of transmission of these amebæ from unsanitary privies to food and drink. Finally, unclean food handlers, cooks, and waiters must always be regarded with suspicion, whether in urban or rural areas.

#### BACILLARY DYSENTERY

This clinical entity, due to bacteria of the *Shigella* group, consists of varied manifestations, depending on the type or strain of the etiologic agent. A few of these types are well known and readily diagnosed; others, including particularly those in warm climates, have been investigated imperfectly and are not readily differentiated. Epidemics of bacillary dysentery are much more likely to ap-

pear in temperate climates than are those due to *E. histolytica*. Yet by and large the epidemiologies of these diseases are similar. In subacute and chronic diarrheas and dysenteries, suspicion should rest both on *Shigella* and on *E. histolytica*, and specific diagnosis of one need not necessarily rule out the other, since they may coexist in the same individual. In acute infections, amebiasis is more likely to produce a dysenteric stool in which red blood cells predominate and cellular debris and pus cells are minimum; in bacillary dysentery, the reverse is true and there is usually much more tenesmus. Likewise, uncomplicated amebiasis does not produce fever and there is no significant leukocytosis, while bacillary dysentery produces a toxic condition with elevated temperature and leukocytosis. There is no eminently satisfactory treatment for bacillary dysentery.

#### TYPHOID FEVER

The public health aspects of this disease are so well known and the value of immunization is so well appreciated that they need not be presented here.

#### CHOLERA

This virulent epidemic disease has not been present in the Western Hemisphere for several decades and need not concern us unless by ill chance it should gain entry to the Americas among refugees repatriated from the Orient.

#### MALARIA

Malaria in man is due to four species of blood parasites belonging to the genus *Plasmodium*, and producing tertian, quartan, estivo-autumnal, and ovale malaria. The first three of these are autochthonous in the United States, although tertian infection is the only one able to maintain itself north of the Ohio valley and in comparable latitudes farther west. Estivo-autumnal malaria is found endemically only in the southern states and in warmer climates, and is

the one malaria type which is primarily responsible for death. Malaria is dependent on the presence of female Anopheline mosquitoes, which serve as alternate hosts and transmitters to man through deposit of minute droplets of their infected saliva in the skin at the time they are taking a blood meal from their victim. Typically, after an incubation period of 10 days or more, the patient has regular periods of severe chills, fever and sweating, with afebrile intervals.

Since its high incidence during the depression years of 1931-1934 malaria has steadily declined in the United States and at the present time is under relatively satisfactory control, although moderate epidemics of tertian malaria were recorded from the upper Mississippi valley during the summers of 1939 and 1940. No such comforting condition exists in Tropical America where malaria remains highly endemic. The return of United States troops from our outlying defense bases in the Tropics is bound to bring many cases of chronic malaria into every part of our country. There will be need for special awareness of this danger; the cases should not only be properly diagnosed and adequately treated but care must be taken to prevent them from serving as sources for infection of Anopheline mosquitoes in nonmalarious areas.

The prognosis for patients who receive adequate early treatment for malaria is relatively good. Full treatment either with quinine or atabrin is usually satisfactory, although relapses will occur in a considerable proportion of these cases. In addition, plasmochin should be administered (along with quinine, but following atabrin) to kill the stages of the malaria parasite which are infective for the mosquito. This is an important phase of the control program for malaria. None of the above drugs nor any other presently known will prevent a person from becoming

infected with human malaria plasmodia, although if taken prophylactically (*i.e.*, in reduced doses) during a period of exposure, quinine or atabrin may prevent symptoms from appearing until after use of the drug has been discontinued.

Precautionary measures to control malaria in an endemic area or to prevent its establishment in a nonmalarious area consist in naturalistic measures, as proper drainage; in the use of oils or Paris green to kill Anopheline larvæ in their breeding places in pools, ponds, irrigation ditches, and slowly flowing streams; in the maintenance of good screening on homes; in the use of pyrethrum and other sprays to kill adult mosquitoes which get into habitations; in the use of repellants, made up in an ointment base and rubbed onto exposed skin; and, of course, in the adequate treatment of all clinical and carrier cases to prevent infection of the Anopheline mosquitoes.

#### YELLOW FEVER

The last yellow fever epidemic in the United States occurred in New Orleans in 1905. Rarely if ever continued throughout the cold months of the year, almost every summer this pestilence lay like a black cloud on our southern horizon from the time of its earliest introduction to our eastern seaboard from the West Indies in 1693. Much earlier it had been brought over to Barbados, Martinique, and other islands of the Antilles with the importation of slaves from Africa. The work of Walter Reed and his associates in Havana had shown how yellow fever could be eradicated from cities by preventing the breeding of the yellow fever mosquito, *Aedes aegypti*. But during the past decade intensive and extensive investigation throughout South America and tropical Africa has demonstrated that there are vast endemic belts of the disease in forested areas outside of the breeding places of the domestic *A. aegypti*. Here

wild mosquitoes which have picked up the virus from unknown reservoirs, are able to transmit it to man when he enters the forest. In this way it can indirectly reach urban communities and flare up in epidemic form if *A. aegypti* has carelessly been allowed to breed.

Thus, the disease, which in 1925 had been believed to be eradicated from the face of the earth, remains a lurking danger to all persons who have not been naturally or artificially immunized. Natural immunity exists in persons who have had yellow fever and have recovered; artificial immunity is conferred by vaccination with attenuated strains of the virus developed in experimental animals or in young chick embryos. Hundreds of thousands of individuals in endemic countries and large numbers of our armed forces who are to be sent to endemic areas have been immunized, and the U. S. Public Health Service maintains a rigorous quarantine inspection on steamships and airplanes coming from yellow fever foci. Nevertheless, *A. aegypti* today breeds in considerable numbers throughout the warmer portions of the United States and it is not impossible to conceive that in this day of rapid air transportation infected persons still in the stage of incubation may escape apprehension at quarantine stations, may shortly become ill and be bitten by the yellow fever mosquito in our Atlantic and Gulf ports. Thus, memory of the yellow fever days of the eighteenth and nineteenth centuries should not be erased from our public health consciousness.

#### DENGUE

Dengue, or "breakbone fever," rarely fatal but very incapacitating, has appeared in epidemic proportions in the Southern United States within the past decade. Like yellow fever, dengue is of virus etiology and is transmitted by the *A. aegypti*. Methods of control call for measures to prevent mosquito breeding.

#### TYPHUS AND OTHER RICKETTSIAL DISEASES

There are today no foci of classical louse-borne typhus in the United States. This pestilential exanthematous disease developed to epidemic proportions in the United States during the nineteenth century following the entry of Irish and Polish immigrants. It had been introduced into Mexico and Central America from Spain three centuries earlier and has remained endemically in the Latin-American highlands as the *tabardillo*. Nevertheless, from our South Atlantic Coast through to Texas we have a milder endemic form of typhus, which is present in rats (hence the designation "murine typhus"), and is transmitted to man by rat fleas. During the past decade this disease has assumed important public health importance in Georgia, Alabama, Louisiana, and Texas, but recent anti-rat campaigns in Savannah have demonstrated the method of control.

Closely related to typhus both etiologically and clinically is Rocky Mountain spotted fever. Until about a decade ago this tick-borne disease was thought to be confined to Western Montana, Idaho, and adjacent areas on the Western slope of the Rockies. Then it was found in wooded areas in Maryland and other states of the Atlantic coast. Now it is known to exist in most of the United States. It has a mortality rate of 5 to 90 percent in different localities. It is not epidemic and is always contracted from wood ticks which have previously taken blood meals from infected rodents which are probably the usual reservoir hosts.

A third rickettsial disease, known as "Q fever" because it was first described from Queensland, Australia, is found in the Bitter Root Valley, Montana, and on the Eastern Seaboard. Its symptoms are primarily pulmonary and may be confused with pneumonia and influenza. Apparently, it is highly communicable.

It is appropriate to refer briefly to the control of these rickettsial diseases.

In the absence of human louse, infestation typhus is transmitted from rats to man by the rat flea, *Xenopsylla cheopis*. Thus this disease can be controlled by campaigns against rats, particularly in and around warehouses and stores housing grains on which the rats feed. There is at present no imminent necessity for attempting immunization of populations in foci of endemic typhus, although typhus vaccine, as yet inadequately tested as regards its protective value, is being given to military forces which are being sent overseas to foci of epidemic typhus. For Rocky Mountain spotted fever there is a very effective vaccine which has proved to confer protection and has been given yearly to thousands of civilians in the highly endemic foci in the Western States. In these foci as elsewhere persons who walk through wooded areas with undergrowth or in clearings near such areas during the warm months of the year should within a few hours divest themselves of clothing and make careful search of their skin and clothing for dark brown molelike objects crawling or attached to their skin. If attached, these ticks should be first anesthetized with a few drops of chloroform before an attempt is made to remove them. All ticks removed from the skin or clothing should be placed in a stout glass bottle and sent, together with a careful description of where and how they were collected, to the National Institute of Health, Bethesda, Maryland, for identification.

Thus far our knowledge of Q fever is too immature to suggest preventive measures.

#### RELAPSING FEVER

Like typhus fever, relapsing fever is epidemiologically of two types. One is louse-borne and one is tick-transmitted. Both are caused by a spirochete of the genus *Borrelia*, which courses through the blood stream. In years past louse-borne relapsing fever was introduced

into the United States by Irish immigrants, but it is now apparently non-existent in our midst. Tick-borne relapsing fever is transmitted by soft-bodied ticks of the genus *Ornithodoros*. It occurs endemically throughout many of our western states and extends south to Argentina and Chile. Wild mammals serve as reservoirs. Infection is incapacitating, but is seldom fatal. Trivalent and pentavalent arsenical drugs are therapeutically specific. Care should be taken to keep out of areas where soft-bodied ticks are prevalent or to remove them as soon after exposure as is possible.

#### PLAGUE

For centuries epidemics of plague have taken a tremendous toll of life in the Old World. This disease apparently first came to the Western Hemisphere in 1899 or 1900 on board rat-infested ships. The disease is produced by the bacillus *Pasteurella pestis* and is usually transmitted to man by the tropical rat flea, *Xenopsylla cheopis*. Usually it manifests itself in bubonic form, but when a human epidemic has got under way, the contagious pneumonic type frequently develops. While small epidemics of plague have occurred in some countries of the Americas almost yearly since 1900, no severe pestilence has developed. Much of this control has been due to ship quarantine and to anti-rat campaigns around wharves and warehouses. Nevertheless, in several areas throughout the Western Hemisphere there are foci in rat and other rodent reservoir hosts. In the United States there is increasing evidence of the extensive distribution of endemic plague in ground squirrels and other rodents from the western slope of the lower coastal Sierras eastward to the prairie states. Occasionally plague in man results from contact with infection in these rodents.

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The second half of Dr. Faust's "Diseases in Warm Climates" will appear in January PUBLIC HEALTH NURSING.



# Nutrition and Tuberculosis

By HORACE R. GETZ, M.D.

**N**UTRITIONAL status is no longer judged solely by weight and appearance. A person today is well-nourished only if he "passes" successfully a number of nutrition tests. Each test determines the individual's relative status in regard to one or more dietary constituents. Considerable data have been collected on healthy subjects so that in 1941 the Committee on Food and Nutrition of the National Research Council felt it logical to make recommendations for some of the specific nutrients.<sup>1</sup> Their statement is our best guide to date of what constitutes a good diet. Healthy persons eating the recommended amounts are usually able to pass the nutrition tests.

There is no good evidence in the literature to exempt tuberculous persons from the recommended dietary for healthy people, but on the contrary there is an abundance of evidence showing that the tuberculous person needs even more of some of the food substances.<sup>2,3,4,5</sup> This is in keeping with the time-honored clinical observation that the tuberculous person is commonly malnourished and frequently becomes more so as the disease progresses. In fact the Greek word for tuberculosis is *phthisis* which means "wasting." Just why the tuberculous person needs more of these nutrients is not entirely clear at present, but it is felt to be a direct effect of the disease on the body processes of metabolism and digestion. The prolonged course of the disease probably depletes body stores of some food constituents that in short-term diseases would be adequate.

Internists generally feel that a patient battles his disease better if he is well-nourished, but when one searches the literature for a scientific basis he finds

little. There are a few well-controlled animal experiments<sup>6,7</sup> that show malnutrition is detrimental to the resistance to infectious disease but there are almost no human data.<sup>8,9</sup> With the present interest in nutrition there probably will be more information forthcoming on this subject.

## MALNUTRITION AND INFECTION

Likewise, it is felt that malnutrition predisposes to infectious disease. Laboratory animal experiments<sup>7,10</sup> support this view. Experiments using human subjects are few and usually not well controlled but they too seem to show a lowered resistance to infectious disease in malnourished persons.<sup>11,12,13,14</sup> The classic "experiment" is the one brought on by the last World War.<sup>15</sup> When Denmark was selling a high proportion of her foodstuffs to Germany, the incidence of tuberculosis and xerophthalmia greatly increased. Just as soon as they could no longer sell their foodstuffs, malnutrition at home was not as evident and the tuberculosis death rate began to drop and xerophthalmia to disappear.

## A DIET FOR THE TUBERCULOUS

For these reasons we believe that tuberculous persons should be well nourished. Specifically then what does the tuberculous person need?

**Calories.** Probably between 2,000 and 3,000 are necessary, or about the same number of calories of energy as the adult leading a sedentary life. We no longer feel that the tuberculous patient should be "force fed" or "stuffed" in order to have him gain weight. The idea that weight gain is synonymous with improvement has long since been proved erroneous. Very frequently patients do gain weight in the sanatorium but a weight

gain is not evidence *per se* of retrogression of the disease.

**Fat.** It still seems very logical to feed the tuberculous person a fairly high fat diet. It helps to carry along the fat soluble vitamins and also gets large amounts of energy to the patient in little bulk.

**Protein.** The tuberculous person probably needs little more protein than the healthy person. The protein should be of "dynamic" quality—*i.e.*, from animal sources. Experimental work has shown that rats on high protein diets survive progressive infection much longer than animals on low protein diets but whether their resistance is fundamentally better is still unknown. Massive loss of proteins as with pleural effusion and drainage must be offset by diet or plasma transfusions.

**Carbohydrate.** This is the balancing item in the diet and should be decreased to allow for the increases in protein and fat. It should be made up largely of fresh vegetables and fruits if possible.

**Minerals.** There has been considerable controversy over the role of minerals in tuberculosis.<sup>17</sup> Many accounts have appeared in the literature, but it still isn't settled whether the bone-building elements have any special part in the resistance to tuberculosis. More carefully-controlled nutrition experiments will eventually bring us the answer. Iron and other metals needed for hemoglobin regeneration are needed especially by those patients suffering large or repeated hemorrhages. It is generally agreed that tuberculous patients do best on a diet rich in minerals, especially calcium and phosphorus. The special salt diets—like other special diets—are in disrepute except in a few localities where they are used for the treatment of extrapulmonary tuberculosis. Their use is largely empiric. They are by no means specific, and cod-liver oil applied to cutaneous tuberculosis is much more effective than the salt-free diet.<sup>18</sup>

#### VITAMINS IN TUBERCULOSIS CARE

Vitamins were used at first without scientific basis, but fortunately we now have specific tests for deficiencies of vitamins A, K, and ascorbic acid. Now their use can be on a physiologic basis. Normal physiologic levels of these vitamins are still being established but enough is known at present to furnish a basis or goal toward which to strive with therapy. Optimal physiologic levels of the vitamins are still largely unknown but probably are still higher than the present accepted levels.

**Vitamin A.** The early work with the biophotometer showed that tuberculous patients had great need for extra vitamin A even when on a good sanatorium diet.<sup>3</sup> The more accurate blood test has confirmed the early findings and is a usable tool with which to follow the progress of treatment.<sup>19</sup> Therapy trials have shown that the tuberculous person needs large doses of vitamin A in order to bring about recovery from the deficiency which is so often found. There is no need for vitamin A therapy unless a lowered blood level can be demonstrated. What effect on the recovery of the patient this restoring of the normal physiologic level of vitamin A has, is a problem for the future. No specificity as an anti-tuberculosis agent is expected but it is hoped that the return to normal of the blood level of vitamin A will assist in returning the patient's resistance to what it would have been if his vitamin A stores had not given out. The functions of vitamin A in the body are so fundamental that a deficiency, as found so often in the tuberculous patient, is very serious—much more so than the deficiency of some of the other vitamins. The dosage of vitamin A should be prescribed and controlled by the physician aided by the laboratory as the therapeutic doses needed at first may be well over 100,000 international units per day.

**Vitamin B.** No good laboratory tests have been developed yet to determine

whether the tuberculous patient needs more of the B vitamins than the healthy person. There seems to be no reason either to suspect that he needs less of the complex. It is suggested that dried brewers' yeast be prescribed by the physician to complement what the dietitian can plan in the menu so that the total B vitamins will equal the quota recommended for healthy people. Dried brewers' yeast is the most economical source of these vitamins and it also helps to combat constipation.

*Vitamin C.* The laboratory tests for ascorbic acid now used are still somewhat unsatisfactory due to the instability of the substance itself. The test is practical, however, in the hands of a well trained individual who understands its weaknesses. The method of measuring the unused portion of dye (2,6 dichlorophenolindophenol) seems more satisfactory than those methods titrating the dye into the plasma filtrate.<sup>4</sup> A photoelectric colorimeter is indispensable for this work. A more profound depletion of ascorbic acid is found in most active cases of pulmonary tuberculosis than of vitamin A. Fever and toxemia seem to deplete readily the meager stores of this vitamin. This deficiency follows the extent and severity of the disease<sup>4,5</sup> as does vitamin A deficiency.<sup>3,4</sup> The restoration to normal of the blood level of ascorbic acid is somewhat easier. Again the physician should prescribe additional ascorbic acid to what is supplied in the diet so that 200-500 mg are consumed daily. This dosage may be changed as the fasting blood level reaches 1 mg percent. Most tuberculous patients need more than 150 mg per day to maintain a blood level above 1 mg percent, which is the accepted minimal normal level.

*Vitamin D.* The bone-building minerals and vitamin D are intimately related and the importance of all these is not clearly understood at present. It seems probable that the tuberculous patient needs more vitamin D for calcify-

ing tubercles, but this is by no means an established fact.

*Vitamin E.* This is probably not needed in excess over that required by the healthy person, since this vitamin appears concerned only with reproduction. There has been no experimental work in this field in tuberculosis.

*Vitamin K.* This vitamin has special significance for the tuberculous person. When hemorrhage is a problem and before surgical operations, it should be given if the clotting time is too slow and a prothrombin test reveals a low level of prothrombin. If the patient is getting all the other food substances as recommended, he probably will be getting enough vitamin K.

#### GENERAL FEEDING PROBLEM

Most nutritional deficiencies are multiple, and the tuberculous patient certainly makes no exception to this rule. The nutritional problem of tuberculous persons is usually not one of quantity but of quality. The need for vitamins A and C seems a peculiarity of the disease. Deficiency in these substances is commonly encountered, and in cases with advanced disease the deficiencies are profound. This in itself tends to complicate the therapy problem, for the advanced cases often have a very disturbed or diseased gastric intestinal system so that regular meals cannot be taken. Frequent small meals may be used and of course milk may be the basis of the fluid diet. Those patients unable to tolerate milk are found frequently and make the problem almost unsolvable. It is preferred to give as much as possible of the food constituents in the form of naturally-occurring food substances, but when food idiosyncrasies and intolerances complicate the problem concentrates and substitutes have to be used.

The dietitian occupies a key position for she must plan and see to it that the patient is getting the recommended food amounts. The diets need not be weighed

as for diabetics, but much more skill is required to keep long-term bed patients eager to eat. When food is not eaten, careful attention should be given as this may be the indicator of progression of the disease or the beginning of a dietary deficiency.

#### SUMMARY

The tuberculous patient should have about the same number of calories as the healthy person leading a sedentary life. He should have at least as much of the

dietary nutrients as the Committee on Food and Nutrition of the National Research Council has recommended for healthy persons, and should have in addition extra amounts of those substances of which there seems to be a specific lack. Proteins, fats, and minerals should be generously given. Vitamin A and ascorbic acid are needed so badly that they constitute a medical problem and should be prescribed by the physician, aided by laboratory tests revealing the blood levels of each.

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# Volunteer

## Health

### Assistants

By

DOROTHEA C. WELLS



**T**HE WITHDRAWAL of thousands of nurses from civilian life and their enrollment in war activities created a nationwide shortage a full year ago. At that time New York City was among the centers hardest hit. What has been done to meet the situation in New York provides many suggestions which could be used in similar organizations in other parts of the country.

In addition to the war demands, the work of New York's Department of Health was crippled by budget cuts. A first-class emergency was at hand.

Today, one year later, the work of the Department is being competently taken care of. The crisis was successfully met by training hundreds of volunteer health assistants who are doing an excellent job in the short space of time they have been active. Right now the

professional staff of the Bureau of Nursing of the Department of Health is using the services of 400 or more of these volunteer assistants.

The training is still continuing because it is estimated that 2,000 will be needed to cover the five New York boroughs adequately. The progress to date gives a loud reply of "Yes" to the questions: "Can professional nurses and volunteer assistants work together successfully?" and "Can volunteers be relied upon to fulfill their duties as faithfully and capably as if they were paid?"

The Bureau of Nursing of the Department of Health started thinking about formulating a program in the late summer of 1941. Dr. John L. Rice, then commissioner of health, asked Mrs. Hyman Schroeder to take over the direction of the volunteer health assistants.



The basic plan for their organization was worked out by the director of the Bureau of Nursing and subsequent training was given by Bureau staff. Between the opening of the course in January 1942 and the 31st of August, 17 groups of women were given two-weeks' training consisting of seven two-hour conferences and three three-hour field observation periods in the station to which they would be assigned.

Recruiting is done through various local agencies such as OCD, AWVS, Red Cross, or church organizations. The only formal requirements are that the candidate must have better than high school education and must be between 20 and 45 years old, although some exceptions are made to this upper figure. More importantly, the director of volunteers herself must make the final decision as to whether the candidate shows promise of working successfully in the program.

#### PRELIMINARY TRAINING

In the training conferences the following subjects are taken up:

1. Health department—history, description of work of each bureau, relationship of Bureau of Nursing to other

sections; definition, discussion and illustrations of public health. Given by the director of the Bureau of Nursing.

2. Child health stations—function and objectives; history of changes in theory of child care; work of volunteer health assistants in these stations; relationship of work to war effort. Given by the staff consultant in child hygiene, Bureau of Nursing.

3. Elementary schools—history of school health service; objectives of program; methods for carrying out health program; coordination of school health services with home and other community agencies; relationship of the school health program and the protection of civilian health in time of war; role of volunteer in school health program. Given by the staff consultant in elementary schools.

4. Vocational schools—history and development, kinds and number; relationship to the war effort; role of volunteer in the vocational school program. Given by the staff consultant in vocational schools.

5. Chest clinics—their function; facts concerning tuberculosis and its prevention and control; relation of war to tuberculosis; work of the volunteer in



Job problems are discussed at round table conference

chest clinic. Given by the staff consultant in tuberculosis or chest clinics.

6. Social hygiene clinics—their function; facts concerning venereal diseases, their prevention and control; relation of war to social hygiene; work of the volunteer in social hygiene clinics; relationship of work to war effort. Given by the staff consultant in social hygiene.

7. Discussion conference held with volunteers.

- a. Organization of Bureau of Nursing.
- b. Experience in the service assignment.
- c. Comments and questions.
- d. Discussion of confidential nature of work and professional attitude.
- e. Reading condensed version of Hippocratic Oath.
- f. Bibliography.
- g. Discussion of time keeping and volunteer cooperation and obligations.
- h. Information as to smocks and civilian defense insignia.
- i. Announcement of periodic meetings to discuss volunteer work and some phase of public health work.

This is one of the most important and valuable conferences of the whole training period as it brings back the volunteers who have been observing and working in the field for three days to a conference together. The conferences are handled as round table discussions with each volunteer describing where she worked, what she did, the problems that arose in her own mind or concerning the people with whom she worked. A member of the staff answers the questions. Volunteers who have had assignments in which they were not happy due to a variety of reasons have an opportunity to hear the enthusiastic workers, and in many of the conferences women who had been discouraged and were not going back to their work have been spurred on by the others to continue. This same sort of conference has been repeated every two or three months, including several groups of volunteers.



History taking at a child health station, helping to interpret directions to mother



Handling the multitude of clerical details in the health program of the elementary school



Assisting in examinations at the chest clinic—in these and a hundred other ways volunteers save valuable time of doctor and nurse



#### 8. Written examination.

Although the above conferences, plus the three field observation periods of three hours each, conclude the stated training, we have learned that as each volunteer becomes more experienced in her own field her interest in it grows correspondingly. It is, therefore, important for the director of volunteers to sustain this live interest by making it possible for the volunteer to attend related lectures and secure relevant literature.

#### ASSIGNMENT OF VOLUNTEERS

Following this course comes the assignment of the volunteers. Originally they were assigned only to the elementary schools but they are now working also in child health stations, chest clinics, and social hygiene clinics. This type of job because of its regularity gives women an opportunity to schedule their own lives to accommodate war work.

The Department of Health in the past few months has added night workers in the chest and social hygiene clinics. This gives an opportunity to business women for useful volunteer service and it has proved to be a very successful venture. Many business women have been anxious to do health work but until recent months there was nothing for them to do.

In their various duties, the volunteers supplement the work of the regular nurses, relieve them of certain details, and thereby release them for more professional activities. The individual talents of each volunteer are utilized to the fullest. For instance, artists make health education posters, technicians work on specific problems such as X-ray, laboratory research, and others.

There is nothing static about the program. It was started on a small scale, with the features being dropped that did not work out well, and others added readily as opportunities opened up. The directors are still seeking to improve it, and welcome suggestions from staff mem-

bers and the agencies with which they work. One requirement remains unchanged: from the outset the program itself had to be clearly defined. We had to know where we wanted to go before we could plot our course.

#### DIRECTION OF VOLUNTEERS

The director of volunteers has tremendous responsibilities spreading out in many directions. Hers is the final decision as to whether each candidate is desirable and apt, and no rule of thumb can give her ability to make these judgments. She has charge of the training course. The director works with the supervising nurses on the first general assignment of the volunteer. The actual task to be done is allotted by the supervising nurse to whom the volunteer reports. All assignments are made within reasonable distance from the volunteer's home unless in specific cases she has plenty of time and is able to work anywhere in the five boroughs. After the volunteer goes to work the director works constantly to maintain her interest in the day-by-day work.

Besides her responsibility for the volunteers, the director is in constant contact with the professional staff of the agency to which she is attached. In still another direction, she must stimulate and guide the efforts of her volunteer recruitment agencies. She must always be alert to secure proper publicity for the volunteers and for the services in which they are working, and she must have a definite sense of news value in order to obtain recognition through newspapers and periodicals.

Good directors should be sought after, and many able women who have been executives in personnel work, as was the present director of the New York program, or other types of work are now giving their time to head such programs, either voluntarily, on low retainer salaries, or as regular paid executives of the organizations. Women who perhaps



Nurse directs volunteer in the precise task of sterilizing instruments for use

were never public health or community service conscious are becoming keenly interested in this field. To the extent that the director sees her task and can fulfill it, to such a degree will the program succeed. Good morale and an efficient staff of volunteers with the least turnover in personnel will result from:

1. Good training.
2. Proper placements.
3. Keeping the workers interested and busy, giving them as much responsibility and work as their experience and abilities warrant.

4. Making sure they are conscious of their responsibilities in exactly the same way as are the paid workers.

5. Keeping in steady contact with the workers in the field, bringing them together, giving proper praise or criticism, offering further training in their fields.

6. Creating and stimulating the feeling that they are becoming an important women's auxiliary of trained, intelligent, thinking citizens, who are able to contribute to the better management of their own communities.

The trend of the times should not be missed. Women's auxiliaries are here to stay, not merely as a war measure, but as a vital force in everyday community life. When women volunteers learn how their tax money is spent, when they get to see how the other half really lives, and when they come to feel they can take a part in removing some of the blights on our civilization, then and only then will they take their proper place in the community. There is a fundamental permanent appeal for many women in really being able to contribute some service. There will always be the opportunity for them valuably to supplement the activities of professional nurses.

The pictures are by courtesy of the New York City W.P.A.



### Maintaining Minimum Public Health Nursing

*(Continued from page 662)*

type of service can be entirely eliminated during wartime, three services that must be rated essential and hence continued at all costs are nursing care of the sick in their homes because of overcrowded, understaffed hospitals; care of mothers and young children; and public health nursing for the control of communicable diseases.

# Stamp Out the Master Saboteur

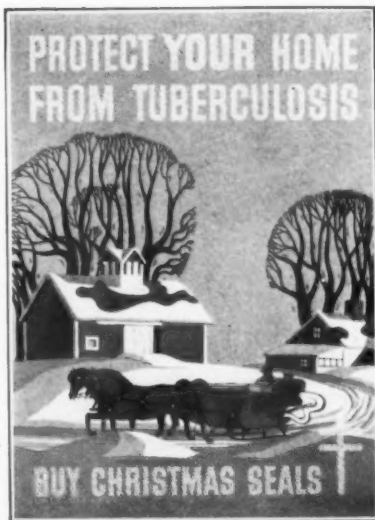
By JANE STAFFORD

A MASTER saboteur threatens our war industries. He is not the enemy agent who sneaks past the guard at the factory gate to light a damaging fire or blow up the plant with hidden dynamite. Neither armed guard nor the FBI itself can detect or stop this saboteur. But you and I and every loyal American can help to detect and stop him by buying 1942 Christmas Seals.

The name of this master saboteur is *mycobacterium tuberculosis*. He is the slender, microscopically small, rod-shaped organism that causes tuberculosis. In the four years, 1937-1940, this deadly creature killed more Americans than died as the result of action in all the wars our country fought up to December 7, 1941.

This germ has been especially hard on our peacetime army of industrial workers and on young girls and women who now are joining the war industrial army by tens of thousands.

In peaceful years here in America tuberculosis caused one out of every four deaths of young women between the ages of 15 and 30 years. Several years ago a special study revealed that it was killing American industrial workers at the yearly rate of 75 out of every 100,000 skilled workers, 100 out of every 100,000 semi-skilled workers, 200 out of



every 100,000 unskilled workers.

Now we are at war, needing the utmost in health and strength to fight on to victory. But because we are at war, this disease threatens us more than ever. Tuberculosis has been called the Fifth Horseman of the Apocalypse. Riding in on the increased tempo of longer working hours, stress and strain, poor nutri-

tion and crowded living quarters, it takes a hugely increased toll of health and life. During the World War of 1914-1918, the death rate of this disease increased 50 percent or more in some of the warring nations and even doubled in certain cities of Europe. Even here in the United States, remote from the actual devastation of war, the tuberculosis death rate, which had been steadily dropping, increased several points.

The great difficulty in fighting this disease enemy is that, like any other saboteur, he works stealthily and under cover. He travels boldly in and out of airplane and tank factories, munition plants and shipyards with every changing shift of workers. Unless he is detected and brought under control he will hinder the flow of guns and planes and shells to our men on the firing line and slow down the production of ships

(Continued on advertising page 8)



# The Industrial Nurse and the Young Worker

By WILLIAM M. SCHMIDT, M.D.

THE INDUSTRIAL nurse today faces many new problems and new conditions, one of which, a very important one, is the increasing number of young workers entering industry. Employment of 16- and 17-year-olds was 100 percent greater in 1941 than in 1940, according to estimates from incomplete employment-certificate reports. Many such are employed in service and non-manufacturing industries, but recently increasing numbers have been obtaining factory work in industries making shoes, machine tools, garments, airplanes, cash registers, and the like. Increases have also been observed in the employment of children 14 and 15 years of age, some going into manufacturing plants not subject to a legal 16-year minimum age because they are not engaged in interstate commerce nor located in states with a 16-year minimum age for such work. In some localities there also appears to be some increase in illegal employment of minors.

Industrial nursing embraces the "prevention of illness and accidents among workers . . ." and the reduction to a minimum of "time lost from employment through illness, whether occupational or nonoccupational."\* The employment of large numbers of minors creates special problems for the industrial nurse, because minors are immature physically and emotionally, and because intellectually, however advanced they may be, they are handicapped by lack of experience, a deficiency which only training and time can remedy.

Adolescent boys and girls 14 to 18

years of age are undergoing rapid physical, mental, and emotional changes in the transition from childhood to adult life. Moreover, at any year of age during this period there is more variation among individuals than there is among adults of a given age. In general it may be said that adolescents are not as big and strong as adults. They are less prudent and have poorer judgment. There is reason to believe that they are more prone to accidents and more susceptible to at least some occupational diseases. As a group they are quick to learn techniques and methods new to them. While they may be better able to do a short sprint of intensive work than an older person, they are probably less able to endure without ill effect exhausting work for sustained periods.

Because young workers require special protection from industrial accident and health hazards, federal and state child labor standards have established minimum ages for certain types of employment and certain requirements for working conditions. The more progressive child labor laws provide a minimum age of 16 years for factory work, and a minimum age of 18 years for certain hazardous occupations. Under federal law (the Fair Labor Standards Act) an 18-year minimum age obtains for the following work:

1. In or about plants manufacturing explosives
2. Driver of motor vehicles and helper thereon
3. In or about coal mines
4. Logging and sawmilling
5. Operation of power-driven wood-working machines
6. In workrooms where radioactive substances are used

\*Johnson, Orlen J. "Nurse's Role in Industrial Health." *PUBLIC HEALTH NURSING*, August 1942, p. 446.

Recommendations for a minimum age of 18 years for employment in a number of other occupations are now in preparation.

A large number of states also provide a minimum age for employment in certain hazardous occupations higher than the general minimum for factory work. Moreover, many states restrict the hours of work, daily and weekly, for minors, and provide limitations upon night work. Employment or age certificates generally should be on file for minors 16 and 17 years of age, and in occupations with an 18-year minimum age, for those 18 and 19.\*

Legal standards, of course, provide only the general framework for appropriate employment and protection of the health and safety of minors. Each factory, mill, mine, or store has individual employment problems and opportunities, and in many there are potential accident and health hazards which must be taken into account in the placement of young workers. The industrial nurse, occupying a key position in relation to management and personnel officers, industrial medical service, and the young worker, can do much to further the protection of young workers' health and safety and to promote their appropriate placement. Pre-employment and periodic physical examinations are, of course, essential to such a program. While the nurse herself does not make medical decisions or offer medical advice, she can often aid the young worker materially in understanding and carrying out the advice he has

received from the physician. Often today the young worker is new and strange in the community, and if he requires medical or related services the industrial nurse who is familiar with local resources is well able to advise him how and where he may obtain help.

The young worker may have had pre-employment training and generally after entering employment some training for his job. Such training should include education in safety and health, but there still remains the need for continued work in safety and health education while he is on the job. In addition to her participation in the plant's general safety and health education program, the nurse has an opportunity to give counsel and guidance to young workers whenever they may visit the dispensary. Such individual advice, desirable for all workers, is especially helpful to young boys and girls. They need it and are generally responsive to suggestion from a nurse in whom they have confidence.

In summary, the industrial nurse today should be familiar with the legal standards for employment of young workers and with the philosophy which underlies these standards. She should be aware of the changing and developing nature of adolescence, and should understand the considerable variation to be expected among adolescent individuals. Finally, realizing the young worker's need for guidance and his quick response and ability to learn, the industrial nurse, under the direction of the physician, should participate actively in teaching and counselling the young worker, for the young worker of today is our most valuable raw material. He is the skilled worker of tomorrow.

\*Further information on legal standards may be secured from the Industrial Division, Children's Bureau, U.S. Department of Labor, Washington, D.C., and from state departments of labor.

# Compilation of an Examination\*

By CECIL R. BROLYER

THE PREVIOUS two articles in this series were concerned with the rationale of an examination and with the construction of its separate items or questions. This, the concluding article, describes the process of compiling an examination from these individual questions. If the examination has been properly compiled, meanings in terms of performance on the job can be attached to the scores. That is, inferences can be drawn with regard to the expected percentage of nurses making a given score who will also give satisfactory service when appointed to the job.

The compilation of any public merit examination, even if only pretested questions are being used, involves two main questions: Within which of the numerous abilities to be found among the competitors are samplings to be taken? What should the difficulty of the examination be?

The first question is concerned with decisions as to when performance on separate items can be combined into a single score and when not. In short, when do we gain and when do we lose information by combining an individual's scores on the items or subtests of an examination? Attempts to solve this problem lead immediately into factor analysis, a branch of psychometrics with which this article cannot deal because of lack of space. It may be that solutions to this problem had better be left to future generations of examiners inas-

much as the present tendency is for examiners to plunge blindly and gaily into the silences and come out with something *called* an examination. If the examiner has included 120 items in the examination, why of course they are all to be added to one score representative of the examinee's ability in "something" and that "something" is the phrase printed at the top of the examination. This problem of the combination of items is by no means negligible. In present-day public merit examinations, however, it is probably not so acute as that of the lack of reliability in the individual items or as that of the difficulty of the examination as a whole.

## JOB PERFORMANCE AND TEST SCORE

Ideally, before we try to establish a passing point on an examination, one in public health nursing for example, we should attempt to discover the percentage of public health nurses at each score level who give satisfactory performance on the job. As an illustration let us say that 95 percent of the nurses who make Score Z on the examination are giving satisfactory professional services. Of those making Score Y, 90 percent are found to be doing satisfactory work. As the scores decrease, smaller and smaller percentages of the nurses making those scores are found to be satisfactory. For some score in the series, some such decision as the following statement must be made: *The passing point is to be that score, S, for which the percentage, P, of nurses obtaining that score give satisfactory performance on the job.* Obviously, numerical values for these symbols cannot be obtained until an examination is itself tested prior to its use to test nurses.

\*This is the third of three articles on the principles and construction of merit examinations for public health nurses. The first and second appeared in the October and November issues respectively of PUBLIC HEALTH NURSING.

There is a fair amount of *evidence* in the field of psychometrics that a person is "measured" most accurately by items that are reliable and valid and that are answered correctly by approximately 50 percent of those of his general level of ability. As a group of competitors becomes more heterogeneous, however, cognizance must be taken of this increased heterogeneity. Items must be provided that will order as adequately as possible the extremes of the distribution as well as the middle.

If the purpose of the examination is merely to order the competitors validly and if the examiner does not have to develop an anxiety neurosis about the *passing score*, the main problem of the examiner is to select such a series of valid tasks that the scores are distributed as much as possible with no zero scores and no *perfect* scores. It is doubtful if any distribution of difficulty of individual items can be established to fit all examinations. Probably the most efficient distribution of difficulty of items should be determined in light of each new examination problem. It should be needless to say that the indices of difficulty of the individual items should be determined from the performance of a group of nurses comparable to the group being examined.

In such an examination, the mean score will be about 50 percent of the total number of items. There will be no zero scores, but there will be some just-not-zero. Likewise there will be no perfect scores, but there will be some scores just-not-perfect. The standard deviation of the scores will be about 16 percent of the total number of items.

One distribution of difficulty of items in which such a distribution of scores will be obtained is shown in the following listing. For example, 10 percent of the items are answered correctly by between 85 and 89 percent of the competitors, 10 percent by 77-85 percent, or a scale such as this:

10%	85%-89%
10%	77%-85%
10%	69%-77%
10%	60%-69%
10%	50%-60%
10%	40%-50%
10%	31%-40%
10%	23%-31%
10%	16%-23%
10%	11%-16%

In such an examination the expected percent of competitors which will answer a given percent of questions correctly is outlined below. For example, about 10 percent of the competitors will answer about 70 percent of the questions correctly, 20 percent, 64 percent, or as follows:

10%	70%
20%	64%
30%	58%
40%	54%
50%	50%
60%	46%
70%	42%

#### RATIONAL PASSING POINT

If a passing point is to be established on a rational basis, certain kinds of information should be available. The performance of comparable groups of nurses on earlier and comparable examinations should be known. Adequate indices should be available as to how well comparable groups of nurses perform on the job. Standards or definitions of "satisfactory performance" should be available so that some such statement as the following can be made: "It has been found that of a random group of nurses comparable to those taking this examination the percentage that would give satisfactory performance on the job is *P*." The passing score should then be such a score, *S*, that *P* of the competitors answered *S* or more of the questions correctly.

If, for example, it had been found that 70 percent, not more and not less, of a comparable group of nurses had given satisfactory performance on the job, then the passing point on the examination outlined above should be 42

percent of the questions. By means of standard and elementary mathematical transformations, the score represented by 42 percent of the questions might be called something other than 42 percent.

#### THE ARBITRARY PASSING POINT

Some merit system agencies, however, work under rules that arbitrarily establish the "passing point" as a certain percentage of the questions. Cognizance of such a rule should be taken in the compilation of an examination. This is in order that the percentage of a random group of competitors who answer at least this fixed percentage of questions correctly may be equal to that percentage of a comparable and random group of competitors who would be sensed by their professional colleagues as giving satisfactory performance on the job.

Assume for example that the merit system agency is operating under a rule that provides for a "passing point" that is 70 percent of the questions. If the examination had been compiled from efficient questions, that is if there was no deadwood among the questions, roughly only 10 percent of the competitors would have answered 70 percent or more of the questions correctly. Probably, the consensus of public health nurses competent to judge would be that for most groups of competitors more than 10 percent would give competent professional service. Thus, enough "easy" or "deadwood" items have to be added to the examination that the desired percentage of competitors will obtain the mystic 70 percent. These easy items actually do nothing whatsoever to enable the examiner better to make a judgment about the relative merits of the competitors. These extra items simply shift the point from which one starts counting.

For example, if one adds these easy items to the extent of 20 percent of the number of items in the original examination, 20 percent of the competitors will answer approximately 70 percent of the

new number of items correctly. If 30 percent of the competitors are to pass (*i.e.*, answer 70 percent of the new number of items correctly), 40 percent of the original number of items have to be added. If 40 percent are to pass, add 53 percent of the original number of items. To establish a passing point such that 50 percent, 60 percent, or 70 percent of the competitors would pass, add 67 percent, 80 percent, or 93 percent respectively of the original number of items.

The reader can easily check for herself the number of easy items to be added by finding such a number that, when added to both the numerator and denominator of the percentage of items answered correctly in the original examination, causes the new ratio to become 70 percent. For example: What is the number,  $x$ , which when added to the numerator and denominator of 64 percent causes the ratio to become 70 percent?

$$\begin{aligned} \frac{64 + x}{100 + x} &= .70 \\ 64 + x &= .70(100 + x) \\ 64 + x &= 70 + .70x \\ .30x &= 6 \\ x &= 20 \end{aligned}$$

Ordinarily these easy questions are not added on to the examination so rationally. Instead, adjustment to the mystic 70 percent is made more or less unintentionally and unconsciously by making all of the questions fairly easy. The net result is that frequently the better-qualified competitors are not given an opportunity to exhibit their superiority.

The development of an examination from which we can draw valid inferences about our fellow men is neither an easy nor a simple task. It is expensive, in terms both of time and of energy. Such a development is important, however, if the judgments made of our fellow men are not to be highly individualistic, partial, and personal to the examiner happening to make them.



In these three articles the writer has tried to bring to the attention of public health nurses some of the basic principles and concepts of examining. Little original thinking has been involved. Practically all of the ideas involved in these articles can be found in the more technical literature on examinations.

The writer trusts that public health nurses will be interested in exploring further the articles and books on examinations and that they will not allow themselves to be irrevocably frightened

from ever helping in the construction of examination materials. It will probably be many years until merit examinations are developed on experimental bases. Meanwhile nurses will need to continue making judgments about the professional competence of other nurses, and such judgments constitute examinations. In the field of the customary written examination it will probably be necessary for many years for the nurse-examiner to develop examinations intuitively—on a basis of guesswork and “common sense.”

### **N.O.P.H.N. Studies Bedside Nursing**

*(Continued from page 658)*

Here, the problem seems to be: (1) augmenting the total public health nursing personnel through some national system of distribution whereby public health nurses from more generously served communities might be assigned to communities of particular need (2) perfecting the coordination of nursing services in these communities so that they can be utilized to their fullest extent.

The remaining 6 communities of the 13 in our preliminary sample have more public health nurses to population but no better provisions for nursing care of the sick or of maternity patients in their homes. Other essential public health nursing services, such as communicable disease nursing, are also missing in some. A high degree of specialization both of administration and of service in many instances stands in the way of adequate distribution of existing resources over the total population for all of the types of service needed.

If the conditions found in the communities included in the 1942 N.O.P.H.N. study are typical of many localities, and it is believed they are, the resolutions of the State and Territorial Health Officers and the American Public Health Association would appear timely indeed. Early local action is a must, through the initiative of public-minded citizens and

public health workers with all the help that they can get from state and national sources.

### **Public Health Nursing Aim**

*(Continued from page 658)*

Association endorse the principle that nursing care of the sick in their homes should be an integral part of a community public health nursing program.

From the beginning, the N.O.P.H.N. has held the belief that nursing care should be part of every community public health nursing service and has now accepted this objective as its special wartime responsibility. The Executive Committee on November 6 discussed at length the study of 16 communities now in progress to determine various ways in which home nursing care services may be developed. It was the unanimous opinion of the Committee that the N.O.P.H.N. should devote especial attention during the next two years to helping local communities secure bedside care for sick people in their homes, especially in areas where wartime military and industrial concentrations have created sudden and unhealthy community population growths.

# British Nurses Face the War

By ELISABETH C. PHILLIPS

**I**N 1938 the nursing leaders in Great Britain realized that in the event of war there would be a greatly increased demand for nurses. Therefore, they began to give careful consideration to the problem. The accepted qualification for a nurse in Great Britain is state registration. This is a national registration which is obtainable after the completion of three years' training in an approved school of nursing and after the candidate has taken the governmental examinations which are set up for the purpose.

Since nursing personnel, fully qualified and in sufficient numbers, is an essential part of the health service of any community at all times in war as in peace, the leaders resolved early that in spite of any difficulties or disorganization—and there was bound to be much of both—the supply of fully trained candidates for state registration must be maintained. The Board of Education now has over 60 pre-nursing courses in the country which are taken before students enter the school of nursing, but the basic courses have not yet been shortened because of such courses. In the preliminary schools and in the country branches of hospitals the teaching and nursing experience open to students are much the same as previously. The generally accepted philosophy in Great Britain is that the nurse in training is performing war work just as much as is the graduate nurse. This philosophy has helped to make possible the maintenance of prewar standards of practice and education.

One of the greatest problems was to find new sources from which the work of the trained nurse and the nurses in

training could be augmented. The first step was most important. This was the establishment by the Ministry of Health of the Civil Nursing Reserve early in 1939. In this undertaking, the Ministry of Health is advised by the Civil Nursing Reserve Council, which represents the various nursing organizations in the country. The principal matron in the Ministry of Health is the administrative head of the Civil Nursing Reserve. This reserve is open to recruits of three categories: trained but inactive nurses; assistant nurses; nursing auxiliaries.

The original purpose of the Civil Nursing Reserve was to provide for casualty services proper, in emergency hospitals, first aid posts, rest centers, medical aid posts in shelters, and other places. Since the strain on these services was not as heavy as expected the Civil Nursing Reserve has been extended to cover peacetime services such as nursing in tuberculosis sanatoria and infectious disease hospitals which have had difficulty in retaining adequate staffs.

## TRAINED NURSES

The graduate nurse was to be the pivot of the Emergency Medical Services and it was of first importance that all graduates be made available to serve in time of war. In Great Britain married nurses very seldom continue in any form of nursing and therefore the annual loss to the profession for this reason has been considerable. In addition, it was felt that perhaps there were many nurses who were inactive through early retirement or who had been diverted to other occupations. It was early recognized that luxury nursing must be given up

for the duration of the war and that therefore there would be many potential recruits from the ranks of the private duty group. The Civil Nursing Reserve allows any qualified nurse who is not already engaged in essential nursing (*i. e.*, not employed in a hospital, as a district nurse, a health visitor, or in industrial nursing) to enroll for whole-time paid employment or for part-time—usually unpaid—work. It was decided at first that all reservists might, if necessary, specify the geographic area in which they could serve, although it was emphasized that services of “mobile” members who could go wherever the need arose were of the greatest value. During the past two years, even more emphasis has been put on this point, as it has been in the case of all other types of workers in industry, canteens, fire fighting units, or other essential war work. The principle of mobility of all personnel is being more and more emphasized. It seems to be now well within the realm of possibility that compulsory mobility of personnel in any field may be resorted to if the voluntary system fails. There are indications of this tendency in this country as well as in England.

#### ASSISTANT NURSES

Assistant nurses are being drawn from a group which had begun the three-year course in nursing and for various reasons had failed to complete the course but who had subsequently earned their living by nursing. In this country the group would probably be designated as practical nurses. These nurses are subject to the same restrictions as are the trained nurses who join the Civil Nursing Reserve. One finds them today on the wards of hospitals, in first aid posts, and out-patient departments. They usually but not always receive a steady salary and do full-time work. This salary is less but not much less than that received by a graduate nurse. Mainte-

nance is often provided for them by the hospital. They usually wear a uniform especially designed by the individual hospital.

#### NURSE AUXILIARIES

At the outbreak of the present war, there were in Great Britain many members of the British Red Cross and the St. John's Ambulance Brigade who were qualified in first aid and home nursing. Many of these women had served as V.A.D.'s (members of Voluntary Aid Detachments) in the last war and most of them had had a course of practical experience in a hospital. In the fall of 1939 these people were enrolled in the Civil Nursing Reserve and refresher courses were inaugurated for them. New candidates were recruited and trained. Courses in first aid and home nursing are given by the British Red Cross and St. John's Ambulance Brigade, which for the duration of the war are administered as one body. At first all of this instruction was given at weekly sessions but later additional “schools of intensive training” were set up. These schools are likewise under the auspices of the St. John's Ambulance Brigade and the British Red Cross, and have been established in country houses throughout the country which are loaned and equipped for the purpose by their public-spirited owners. Girls from all sections of Britain and from all walks of life come to these centers for a fortnight's course. They pay a small fee but there is no obligation on their part to continue as nurse auxiliaries. Indeed, many have become so much interested in nursing that at the close of the two-week course they have entered schools of nursing. The sample proved good so they arranged to have more!

After the series of theoretical lectures is completed there follows a hospital ward experience for the auxiliary. At first this experience was for only 50 hours. Later it was increased to 96

hours and even 120 hours, but now it is becoming customary to have it last for a shorter period. This practice is arranged at a time that is mutually convenient to the hospital and to the candidate. At the completion of the training period many auxiliaries are taken on to the organization's staff on a salary, but others offer their part-time services free. Such part-time service is usually given by people who are holding a full-time war job elsewhere. Many of them work from three to five nights a week in first aid posts or in the medical aid posts in the large shelters. (On such nights they usually are able to sleep four to five hours.) The Minister of Health recommends that employment be assured all candidates and that maintenance and uniforms be provided.

Other persons eligible for enrollment as auxiliaries are members of groups allied to nursing such as massage and nutrition groups. The certificate obtained by all who study first aid and home nursing and take the practical course in hospital wards confers no rights or privileges other than that of joining the Civil Nursing Reserve for war service. However there is no legislation in England or Wales which prevents an unqualified woman from practicing nursing for hire. This is not true of midwifery. For this reason many thoughtful people feel that the practical experience in the hospital should be shortened rather than lengthened to emphasize the difference between the auxiliary and the graduate nurse.

The age limit for all three groups in the Civil Nursing Reserve is from 18 to 55 and the rates of pay are fixed by the Ministry of Health. There is a specific Civil Nursing Reserve uniform which any member is allowed to wear, but the auxiliaries usually wear the uniform of the Red Cross or St. John's Ambulance Brigade. The members of the Civil Nursing Reserve may not be sent overseas but they are allocated for

service all over Great Britain through a regional scheme. The general principle governing hospital staffing is that there must be a nucleus of a permanent graduate nurse staff in each hospital which is augmented by a fixed proportion of Civil Nursing Reserve Service workers who are drawn from all three classes. One graduate nurse to eight reservists has been suggested as a good working ratio.

The last figures I have seen for the Civil Nursing Reserve were compiled in March 1940. At that time there were 14,764 trained nurses, 7,822 assistant nurses, and 39,657 nurse auxiliaries, totaling 62,243. This number is in addition to all other regularly recruited and employed nurses. The goal of the Civil Nursing Reserve is 100,000 full-time workers.

#### RECRUITMENT OF STUDENT NURSES

The slogan for recruitment which is used most frequently is "Nursing—Your War Work with a Future." The national emergency leads many girls to enter nursing in order to perform a direct national service. Since the compulsory registration and allocation of women over 18 years by the Ministry of Labor and National Service has been in effect, nursing is one of the five fields which a woman may select and follow voluntarily. The other four are the three women's services, the A.T.S., W.R.N.S., W.A.A.F.\* and the nursery aides. This national registration of women has brought about a higher scale of salaries for nurses. Student nurses recruited by the Civil Nursing Reserve receive a salary of about £40 (about \$200.00) yearly and schools of nursing have found it necessary to pay other students at a similar rate. As a result the salaries of graduate nurses are being advanced. There is no government grant for nursing education but in cases where

\*See "British Women in the War Services" by Elisabeth C. Phillips, *PUBLIC HEALTH NURSING*, November 1942, p. 609.

voluntary hospitals in the emergency medical service scheme have had to increase salaries, the government takes this into consideration and allows extra funds toward hospital expenditures.

In April 1940 the Nursing Recruitment Center was opened in London to give information concerning nursing as a career and to tell potential candidates of the opportunities available in various schools of nursing. It is in reality a public relations department for the voluntary hospitals. This center is financed by the King Edward's Hospital Fund for London. It utilizes the usual publicity channels and has succeeded in enrolling about 1,000 students a year. So far as I know there has been no great increase in the numbers of students in schools of nursing in Great Britain in the past few years. At the present time there are about 90,000 fully-trained registered nurses in England and Wales and another 12,000 who are partially trained—in such special branches as sick children's nursing, fever nursing, or mental nursing.

#### MEDICAL AND NURSING PERSONNEL

In England the Minister of Health is a member of the House of Commons and is not a physician. However, the Chief Medical Officer who is appointed by the Minister of Health is a doctor. At the present time when the needs and demands for action in order to safeguard the health of a nation at war are so imperative, England is most fortunate in having as leaders in the health field men of the caliber of Ernest Brown, M.P., who is Minister of Health, and Sir Wilson Jameson, Chief Medical Officer, who is well-known internationally as a leader in public health administration. A great step forward was taken in 1941 when the office of chief nursing officer and principal matron was created in the Ministry of Health and Miss Kathrine Christie Watt was appointed to fill this post. She is responsible for all nursing activities

carried on by the Ministry of Health. She is also the administrative head of the Civil Nursing Reserve. She has appointed two deputies who are also nurses, one who assists her in hospital administration, and another who is responsible for public health nursing.

#### EMERGENCY MEDICAL SERVICE

The Emergency Medical Services provide workers for both hospital and home emergency care as well as for diagnostic laboratories in rural and urban areas. The Ministry of Health in England and Wales does not administer hospital or casualty services directly. All nursing in the Emergency Medical Services heads up in each sector to a sector matron. Often this person is the superintendent of the largest and most important hospital in the sector, but sometimes, as in Bristol, she is a public health nurse administrator. No matter what her peacetime job was, she now has the responsibility for organizing and administering through the various matrons and public health nursing directors all of the nursing in its many branches throughout her sector. Under the Emergency Medical Services a vast number of hospital beds have been made available for air raid casualties through the establishment of country branches of the hospitals and the evacuation of all transportable patients to them. Likewise this organization in cooperation with hospitals and public health organizations has set up mobile ambulance units, first aid posts, first aid stations, and first aid points. These are all administered by the Emergency Medical Services and are quite separate from the regular hospital or public health staffs. This means that the hospitals themselves rarely send out "mobile" teams of members of their own personnel. Generally speaking, there is an attempt to keep doctors and nurses off the street and out of wrecked buildings, since their skills are thought of as being too valu-



able to risk. They remain in hospitals and casualty stations and the patients are brought to them by lay ambulance staffs and stretcher parties.

#### PUBLIC HEALTH ADMINISTRATION

Public health activities are carried on in England and Wales in much the same way as they are in this country except that the functions of the Ministry of Health (familiarily known as "Whitehall") are more like those of a state department of health in this country than like the United States Public Health Service. Nursing in the public health field is administered by both official and volunteer organizations just as it is in this country. I believe one of the main differences lies in the philosophies in the two countries. They believe in doing things for the patient and family while we believe that our teaching is best when they learn to do things for themselves, yet know where and when to seek professional aid.

There is a complicating factor in the local health authorities, of which there are 140 in England and Wales. These local authorities are, of course, the older organizations just as they are in this country and they form a most important part of the whole health administration. It is not always clear where the lines of responsibility are drawn nor, to a mere American, does the allocation of their functions always seem logical. The Ministry of Health has divided England and Wales into 11 regions for the purpose of public health administration. These regions are usually comprised of four or five counties and are identical with civil defense regions. Large cities are sometimes administered separately. Each region has a regional health officer and a regional nursing officer. The public health education and experience of these physicians is of an excellent standard and the qualifications of the nursing officers are constantly being raised and in some cases are completely satisfactory.

#### DISTRICT NURSES

The Queens Institute of District Nursing carries on bedside programs throughout England and Wales. There are about 9,000 Queens Nurses working at present and it is estimated that another thousand are needed before the country can be nursed satisfactorily. Since the war the programs of the Queens Nurses have been extended in many directions. Often the local groups that employ the nurse have assumed the responsibility for providing the nursing in shelters and rest centers. In the rural areas Queens Nurses are caring for the sick members of the Women's Land Army. In some urban districts they play an important part in nursing. Health visitors are employed by the official health departments. They do the communicable disease control work as well as school and clinic nursing.

When the Emergency Medical Services plans were set up, it was felt that it was most unwise to deplete the personnel in the public health field. Many individual nurses, however, volunteer their free time for first aid or shelter work. It is only now, at the close of three years of war, that the Queens Institute and local departments of health are suffering a severe shortage of qualified personnel. This fall many public health organizations are finding that they must continue their programs which are often larger than in the prewar period, with two thirds or even one half of their peacetime staffs.

#### MILITARY NURSING SERVICES

Nursing services for the armed forces fall under three headings: Princess Mary's Royal Air Force Nursing Service, Queen Alexandra's Royal Navy Nursing Service, and Queen Alexandra's Imperial Military Nursing Service.

All branches employ state registered nurses who hold actual rank in their respective services. Since the outbreak of

*(Continued on page 709)*

# Salaries in Public Health Nursing, 1942

By DOROTHY E. WIESNER AND MARGARET M. MURPHY

THE 1942 salary studies consider salary data of 12,177 public health nurses in 687 agencies. The last United States Public Health Service count of public health nurses, January 1, 1942, shows 21,123 nurses, exclusive of industrial nurses, and the 1940 count of agencies, 6,166 agencies. Our sample, therefore, includes 57.6 percent of the total number of public health nurses and 11.2 percent of the total number of agencies. It is evident from these figures that the smaller agencies are not proportionately represented in the sample. The 687 agencies which replied are 55.8 percent of the total number of those to whom requests for data were sent. The returns include data from 253 non-official agencies, 212 local health departments, 156 departments of education, 15 combination agencies, 42 state departments of health, 7 state and local welfare agencies, and 2 territorial agencies.

The 48 states are grouped into nine divisions by the U. S. Census Bureau. Our 1942 sample is most adequate for the East North Central states, since we have salary data for 58.2 percent of the nurses employed there. The sample is least adequate for the Mountain states since we have salary data for 22.4 percent of the public health nurses employed there.

So far as kind of agency is concerned, our sample is most adequate for the non-official agencies since we have data for 65.4 percent of the nurses employed by such agencies. The sample is least adequate for the department of education agencies, since we have data for 31.6 percent of the nurses employed by these agencies. Salary data for industrial nurses were not attempted for this review.

These paragraphs indicate something of the value and limitations of this review. It is not practicable to present here all of the detailed material from which following comparisons are drawn. Special lists and comparisons will be supplied upon request for local use.

Of the 687 agencies which returned 1942 salary data, 430 also returned salary data for 1938. In a later report, comparisons will be made to show changes between these periods.

Table I shows the kind of nurses for whom we have 1942 salary data by seven types of employing agency according to geographical location. PUBLIC HEALTH NURSING for August 1942 contained "State Salaries in Public Health Nursing." This report gave data about the 2,501 nurses paid entirely by 42 state health departments. Data about these nurses have not been included in this review.

Variations according to kind of agency, size of agency, and geographical location are of interest. It is necessary to consider these factors in comparing salaries. Since the size of population served, and the size of agency are so closely related, the salary data are not given by population served.

## 1. SALARIES IN NONOFFICIAL AGENCIES

Of the 645 agencies included in this study, 253 were nonofficial. Of these, 232, or 91.7 percent, were member agencies of the N.O.P.H.N., who feel a special responsibility for returning Yearly Reviews. The 253 agencies varied from 30 one-nurse agencies, to 7 employing 100 nurses and more. The total number of nurses employed was 3,657. Table II shows the number of nurses in these non-official agencies according to size of agency and by position on the staff.

### BY SIZE OF AGENCY AND POSITION ON STAFF

The salaries of the *directors* and *assistant directors* of these 253 nonofficial agencies varied from \$120 a month in two small agencies to \$350 and over in 16 large agencies. The median salary among the 197 directors was \$221. Fifteen of the 30 directors and assistant directors of agencies employing 50 nurses or more earned \$350 or more. The median

TABLE I  
NURSES IN THE SALARY STUDY BY GEOGRAPHICAL LOCATION AND KIND OF EMPLOYING AGENCY

By geographical location	Total nurses in 1942 salary study sample	Kind of employing agency							
		Nonofficial	Health depart-ments		Departments of education	Combination agencies	State <sup>1</sup> depart-ments of health	State <sup>2</sup> and local departments of welfare	Territorial agencies
			Municipal	County and district					
Total nurses in sample	12,177	3,657	3,169	1,006	1,237	198	2,501	41	368
New England	1,225	674	250	....	131	10	160	....	....
Middle Atlantic	3,511	1,368	1,139	121	351	63	466	3	....
East North Central	2,507	837	1,020	175	160	46	260	9	....
West North Central	891	307	102	67	200	26	174	15	....
South Atlantic	1,122	236	309	175	50	10	337	5	....
East South Central	449	38	79	142	1	....	189	....	....
West South Central	890	44	43	63	79	....	652	9	....
Mountain	314	43	....	77	28	....	166	....	....
Pacific	891	110	227	186	237	34	97	....	....
Other <sup>3</sup>	377	....	....	....	....	9	....	....	368

<sup>1</sup> See PUBLIC HEALTH NURSING, August 1942, for complete report on this group.

<sup>2</sup> Includes data from 6 state agencies and 1 city agency.

<sup>3</sup> Includes data about 19 nurses in Alaska, 9 in Hawaii, and 349 in Puerto Rico.

monthly salary for the 21 directors in agencies of 25-49 nurses was \$260. This salary was also the median salary for similar positions in agencies of 15-24 nurses. Among the agencies of 10-14 nurses, the median salary was \$219, and among those employing less than 10 nurses, the director's median salary was \$190. In no instance was the nurse in a one-nurse agency classified as a director.

The 253 nonofficial agencies employed 34 *educational directors*. Two earned \$300 or more; eighteen earned from \$200 to \$299; 13 earned between \$150-199. One person in an agency employing 10 nurses was termed an *educational director* although the salary was only \$125.

*Generalized supervisors* in the sample numbered 323, and *specialized supervisors* 59. The median salaries for these two groups were \$167 a month for the generalized and \$168 for the specialized. Specialized supervisors, however, showed a wider range of salary and were better paid in larger agencies than were generalized supervisors. In agencies employing 50 and more nurses the median salary among specialized nurses was \$202, and among generalized was \$170.

The median salary of the 2,893 *generalized staff nurses* was \$134. Only 1 earned \$200 or

more (a nurse working alone), and 29 earned less than \$100. Nurses in agencies of 50 nurses and more received higher salaries than those in smaller agencies. The median for the 30 one-nurse agencies, however, was the highest of all, \$153 a month.

*Specialized staff nurses* numbered only 151 in this sample of 253 agencies. They were found in agencies of all sizes, and the median salary for these nurses was higher than for the generalized—142 for the specialized staff nurse as compared with \$134 for the generalized.

#### BY LOCATION AND POSITION ON STAFF

It has been shown that *directors' salaries* are higher in large agencies, and it is therefore to be expected that the parts of the country with large cities are likely to pay higher salaries to their directors. The Middle Atlantic states show a median salary to directors of \$254, as compared to a median of \$221 for agencies all over the country. Among the 19 Southern agencies, the median salary to a director was \$229. The smaller agencies in the New England and Central states account for the lower median salaries for these areas.

Of the 34 *educational directors*, 12 were employed in Middle Atlantic agencies, and 6 in the New England states. Salaries for these 18 varied from \$150 to \$350 and over. Nine were

TABLE II  
NURSES IN SAMPLE OF 253 NONOFFICIAL AGENCIES BY SIZE OF EMPLOYING AGENCY  
AND POSITION ON STAFF

Size of employing agency	Total nurses in sample	Position on staff					
		Director and assistant director	Educa- tional director	General- ized supervisor	Special- ized supervisor	General- ized staff nurse	Special- ized staff nurse
Total nurses on staff	3,657	197	34	323	59	2,893	151
100 and over	1,029	14	6	122	11	861	15
50-99	601	16	7	60	15	474	29
25-49	511	21	9	40	14	406	21
15-24	496	28	10	33	12	363	50
10-14	306	30	2	19	5	239	11
5- 9	461	60	.....	29	1	354	17
2- 4	223	28	.....	20	1	166	8
1	30	.....	.....	.....	.....	30	.....

employed in the Middle West, the highest salary being \$260. Six were employed in Southern states, the highest salary being \$250.

So far as *generalized supervisors* are concerned, salaries were higher in the Southern states, and in the East North Central, although the figures for the Southern states are rather scanty to discuss. Among 18 *generalized supervisors* employed by 19 Southern agencies, the median salary was \$173, and among 72 such *supervisors* employed by 47 agencies in the East North Central states, the median salary was \$171. These figures are to be compared with the median of \$167 among the total 323 *generalized supervisors* in the sample.

About half of the *supervisors* in our sample, both *generalized* and *specialized*, were employed by 73 agencies in the Middle Atlantic states. The median salary among the Middle Atlantic *specialized supervisors* was \$195, as compared with \$168 for all such workers. Only 5 were employed by Southern states, and their salaries were all below the median of \$168.

When compared by medians for parts of the country, *generalized staff nurses' salaries* varied from \$123 in the East South Central states, to \$144 in the Pacific states. The widest variations appeared in the Middle Atlantic states, in which 2 nurses received less than \$90 and one nurse received \$200. Although half of the *supervisors* were employed in the Middle Atlantic states, only three eighths of the staff nurses were employed in this area.

Of the 151 *specialized staff nurses*, 52 were employed in the Middle Atlantic states, and the median salary among them was \$151, as compared with the median salary of \$142 for all *specialized staff nurses*, and of \$135 for *generalized staff nurses* in the Middle Atlantic states.

#### 2-a. SALARIES IN MUNICIPAL HEALTH DEPARTMENTS

The 94 municipal health departments in this sample varied from 6 one-nurse agencies to 8 employing 100 nurses and more. The total number employed was 3,169. Table III shows these nurses by size of employing agency according to position on the staff.

##### BY SIZE OF AGENCY AND POSITION ON STAFF

In 35 municipal health departments no nurse was called "director." The median salary among the 71 *directors* and *assistant directors* for whom data were received was \$208. Among the 22 departments employing 50 nurses and more, the median salary was \$241, as compared with \$350 as the median for similar positions in nonofficial agencies. Two *directors* of large departments received \$350 or over, and 4 received less than \$200. Salaries of *directors* were less in the smaller departments. The median salary for 19 *directors* in municipal health departments employing 10 to 24 nurses was \$211, comparable with \$208, the median for the entire 71 *directors*. For *directors* in departments employing less than 10 nurses, the median salary was \$169.

Only 7 *educational directors* were employed by the 94 municipal health departments. Their salaries varied from \$158 in a 42-nurse agency to \$417 in a department employing more than 100 nurses. The salary of the latter nurse was, however, paid from private funds. It is of interest to see that 3 departments of 25-49 nurses employed *educational directors*, their salaries ranging from \$158 to \$218. The nurse receiving \$218 served as *educational director* for both the municipal and county health departments in a Southern state.

TABLE III  
NURSES IN SAMPLE OF 94 MUNICIPAL HEALTH DEPARTMENTS BY SIZE OF EMPLOYING AGENCY AND POSITION ON STAFF

Size of employing agency	Total nurses in sample	Position on staff					
		Director and assistant director	Educa- tional director	General- ized supervisor	Special- ized supervisor	General- ized staff nurse	Special- ized staff nurse
Total nurses on staff	3,169	71	7	185	92	2,320	494
100 and over	1,926	14	2	140	36	1,596	138
50-99	397	8	2	14	30	219	124
25-49	270	8	3	12	7	165	75
15-24	220	10	.....	7	12	107	84
10-14	165	9	.....	8	4	126	18
5- 9	107	7	.....	4	1	62	33
2- 4	78	15	.....	.....	2	40	21
1	6	.....	.....	.....	.....	5	1

The median salary among the 185 *generalized supervisors* was \$207, as compared with \$167 for similar positions in nonofficial agencies. Of the 185 generalized supervisors, 125 received \$200 and over; 117 of the 125 were employed in agencies of 100 and more nurses.

*Specialized supervisors* in municipal health departments received considerably less, however, than did the generalized supervisors. Their median salary was only \$168. One reason for the variation was the fact that 140 of the 185 generalized supervisors were employed in the 8 departments of 100 and more nurses in which the salaries are high. Only 36 of the 92 specialized supervisors were in such departments. The median salaries of the specialized and generalized nurses in these large health departments were \$211 for the generalized supervisors, and \$210 for the specialized supervisors. Among the 19 generalized supervisors in departments of 15-49 nurses, the median salary was \$170. Among the 19 specialized supervisors in departments of 15-49 nurses, the median salary was \$155.

The employment of specialized supervisors is more usual in the municipal health departments than in the nonofficial agencies. Of the 277 supervisors in the municipal health departments, 92, or 33.2 percent were specialized. Of the 382 supervisors in the nonofficial agencies, only 59 or 15.4 percent were specialized.

The median salary among 2,320 *generalized staff nurses* in the municipal health departments was \$157, as compared with \$134 for similar positions in nonofficial agencies. Salaries were highest for staff nurses in agencies of 100 nurses and more, and lowest in agencies of 25-49 nurses. The inclusion of 2 departments in Southern cities which paid salaries of

less than \$100 to Negro nurses, accounts for the peculiarly low salaries in departments of this size. It was noted that in nonofficial agencies, the nurse in a one-nurse agency received a higher salary than in larger agencies. This does not seem true for municipal health departments. There were only 5 departments employing 1 generalized nurse in the sample, but only 1 of the 5 received \$160 or more; the salary of the middle nurse was \$142. Among the 40 nurses in 2-4 nurse departments, 5 received \$160 or more and the median salary was \$149.

Among the 494 *specialized staff nurses* in these 94 municipal health departments, the median salary was \$132. This is to be compared with \$157 paid to generalized staff nurses in municipal health departments and \$142 paid to specialized staff nurses in nonofficial agencies. In 22 municipal health departments in the sample, every staff nurse was specialized, and in one city employing 95 such nurses, the highest salary paid a staff nurse was \$125. This city accounts in great part for the low median shown for specialized staff nurses.

It was indicated above that the employment of specialized supervisors was more usual in municipal health departments than in nonofficial agencies. This is true, too, in the employment of specialized staff nurses. Of the 3,044 staff nurses in nonofficial agencies, only 151, or 5.0 percent, were specialized. Of the 2,814 staff nurses in municipal health departments, 494, or 17.6 percent, were specialized.

#### BY LOCATION AND POSITION ON STAFF

When the salaries of *directors* and *assistant directors* in municipal health departments were reviewed to see whether there were variations according to sections of the country, it was



evident that the 8 directors in Pacific Coast departments were better paid than were those in other sections, the middle salary being \$220. For the 13 directors in the Southern states, the median salary was \$219. The New England and Middle Atlantic states showed lower medians. Of the 6 nurse directors of municipal health departments in the West North Central States, the best paid received \$200, and one received only \$140. The middle salary was \$178.

The 7 *educational directors* were employed by agencies in 6 states, 5 states east of the Mississippi, and 1 other in California.

Salaries of *generalized supervisors*, as measured by medians, were \$210 and over in the Middle Atlantic and East North Central states and below \$160 in the South Atlantic states. Of the total 185 generalized supervisors in the sample, 70.3 percent were employed in the Middle Atlantic and East North Central states.

Salaries of *specialized supervisors* were also higher for the 31 nurses in the East North Central states, with a median of \$172, than for the country as a whole. In the Middle Atlantic states, however, such salaries were lower, the median for this group being \$158. In the Pacific Coast states, from a sample of 9 agencies it would seem that specialized supervisors there are more highly paid than generalized. While there were only 14 of each kind in the sample, the median for the specialized supervisors was \$208, and for the generalized, \$160.

Because of some of the large municipal health departments in the Middle Atlantic states, and the higher salaries paid in them, the median salary of *generalized staff nurses* is highest in this part of the country, \$178, as compared with a median for the entire country of \$157. The median salary among 337 generalized staff nurses in the South is low, \$132. In the Pacific states again the salaries are higher, \$157 being the median among 127 such nurses there.

For the *specialized staff nurse*, salaries are higher than the median of \$132 in the West North Central states. Two agencies here paid \$150 and over to 26 such nurses. Salaries for specialized staff nurses are highest in the Pacific states as measured by the median of \$182 among 63 such nurses. Only 4 of these 63 received less than \$150. Among 44 specialized staff nurses in the Southern states, the median salary of \$126 was low. There are evidently significant variations in the use of specialized staff nurses from section to section of the country, and also in the value placed on their services—the Pacific Coast municipal health departments employing a larger proportion of specialized staff nurses, and paying them better, than do such agencies in other parts of the country.

## 2-b. SALARIES IN COUNTY HEALTH DEPARTMENTS

Of the 645 agencies included in this sample, 118 were county and district health departments. The 118 county departments varied from 9 one-nurse agencies to 2 of 50 or more nurses. The total number of nurses employed in this sample was 1,006. Table IV shows the number of nurses by size of agency according to position on staff.

### BY SIZE OF AGENCY AND POSITION ON STAFF

The salaries of the *directors* and *assistant directors* in these 118 county health departments varied from \$110 in a department of 4 nurses, to \$333 in a department of 35 nurses. The median salary among the 49 directors was \$178. However, among the 12 directors of county departments employing 15 nurses and more, 10 received a salary of \$200 or over and the lowest salary among the 12 was \$175. Of the 28 directors in departments employing less than 10 nurses, the median salary was \$159.

Only one *educational director* was employed in these county health departments. She received \$220, and worked in the largest county department in the sample, which employed 95 nurses.

The median salary for *generalized supervisors* in these 118 county health departments was \$164. There were only 66 such workers, however. Salaries of such supervisors in the departments employing 15 and more nurses were higher than in the smaller agencies, the median among 30 workers in the larger departments being \$185.

There were only 6 *specialized supervisors* reported by these county health departments, or 8.3 percent of the total 72 supervisors. This is in contrast to the 33.2 percent of specialized supervisors reported by the municipal health departments, and to the 15.4 percent by the nonofficial agencies. The salaries of the specialized supervisors varied from 1 nurse who received \$103 as supervising nurse in a venereal disease clinic in an 18-nurse department, to \$179 paid a tuberculosis supervisor in a 95-nurse department.

Among the 827 *generalized staff nurses* in these county departments the median salary was \$135. Salaries were higher in the 25-49 nurse services, the median for 105 such nurses being \$156. Salaries for nurses working in county departments of less than 15 nurses, however, were definitely below those in the municipal health departments of the same size. It is interesting to see that in the 9 one-nurse county departments the middle salary was \$150. This is almost as much as the \$153 paid in one-nurse nonofficial agencies.

There were 57 *specialized staff nurses* in the

TABLE IV  
NURSES IN SAMPLE OF 118 COUNTY HEALTH DEPARTMENTS BY SIZE OF EMPLOYING AGENCY AND POSITION ON STAFF

Size of employing agency	Total nurses in sample	Position on staff					
		Director and assistant director	Educa- tional director	General- ized supervisor	Special- ized supervisor	General- ized staff nurse	Special- ized staff nurse
Total nurses on staff	1,006	49	1	66	6	827	57
100 and over	....	....	....	....	....	....	....
50-99	153	2	1	9	2	134	5
25-49	123	5	....	10	1	105	2
15-24	161	5	....	11	3	127	15
10-14	170	9	....	9	....	130	22
5- 9	296	19	....	24	....	240	13
2- 4	94	9	....	3	....	82	....
1	9	....	....	....	....	9	....

118 county departments, and their median salary was \$133, slightly below the median salary paid generalized staff nurses in these departments. The employment of specialized staff nurses was more usual in the smaller county departments, and salaries were lower in the smaller departments.

#### BY LOCATION AND POSITION ON STAFF

Of the 49 *directors* and *assistant directors* in this sample of county health departments, 34 were employed in departments east of the Mississippi and 15 in departments west of the Mississippi. Salaries of directors were higher in the East than in the West. The highest salary, \$333, was paid to a county director in a 35-nurse agency in New York state, and the lowest, \$110, to an assistant director in a West North Central department, this being a 4-nurse agency.

Tabulations of salaries of *generalized supervisors* in these county departments considered by parts of the country are of interest in indicating that the title of the head nurse may be director in one organization and in a similar organization the title may be supervisor. Among 11 directors in 21 agencies in the Far-Western states, the middle salary was \$160. Among 17 supervisors in the agencies in these states, the median salary was \$179. It would seem that some of these supervisors are carrying similar responsibilities to directors.

Three of the six specialized supervisors were employed in Southern states, and 2 in California. The highest paid specialized supervisor was in a county in California, and she received \$179.

*Generalized staff nurses* in these county departments received higher salaries in the Middle Atlantic states than elsewhere, 24 of the 105

in these states being paid \$200 or more. The median salary among these 105 was \$156. In the Far-Western states salaries for such nurses were also higher than the median for the entire 827, since among 217 staff nurses in these states the median salary was \$148, as compared with \$135 for the entire 827. The Southern states paid low salaries, the median for 311 nurses in these states being only \$126.

Similar comparisons appear for *specialized staff nurses* in the county health departments. Although this sample is scanty for such comparisons, salaries appear higher in the Pacific states, and low in the Southern states.

#### 3. SALARIES IN DEPARTMENTS OF EDUCATION

Among school nurses, salaries have been tabulated on an annual rather than monthly basis, because some school nurses are paid by the school year, and some by the calendar year. Another difference between school nursing services and other public health nursing services is the lack of nurses designated as supervisors. In this sample of 1,237 school nurses, only 64 were designated as supervisors. For the purposes of this review, all nurses above the staff nurse level were included in one category. There were 42 specialized school nurses among the 1,237. Mention of the location and kinds of specialized school nurses appeared in PUBLIC HEALTH NURSING.\* The number of school nurses employed on smaller staffs is evident, since of the 1,237 school

\*Wiesner, Dorothy E., and Murphy, Margaret M. "Similarities and Variations in Programs." PUBLIC HEALTH NURSING, February 1942, p. 100.

nurses in the sample, 191, or 15.4 percent, were on staffs of less than 5 nurses, and 44 of these were working alone. Among the non-official agencies, only 6.9 percent were on staffs of less than 5 nurses; among the municipal health department nurses only 2.7 percent; and among the county health department nurses, 10.2 percent. The greater number of smaller nursing staffs in departments of education accounts in great part for the scanty sample of school nurses. It is obviously more difficult to secure data about 44 nurses in one-nurse agencies than about 44 nurses in 2 or more nurse agencies. Table V shows the school nurses by size of employing agency according to position on the staff.

#### BY SIZE OF AGENCY AND POSITION ON STAFF

Among the 64 supervisors and assistant supervisors of school nurses the median salary was \$2,187. The highest salary paid was \$4,600 and the lowest \$1,440. The person earning \$4,600 was supervisor of a staff of 54 school nurses. There were wide variations, however, among supervisors on staffs of 50 or more nurses. The middle nurse among 11 on staffs of this size received only \$2,280, about \$100 more than the median for all supervisors. Salaries among 10 supervisors on staffs of 25-49 measured by the median, \$2,588, were higher than for the supervisors on the staffs of 50 and over. Two supervisors on such staffs received more than \$3,000, and 5 received between \$2,400 and \$3,000. As might be expected, supervisors on smaller staffs received lower salaries. However, two supervisors on staffs of 5-14 nurses received more than \$3,000.

Among the 1,131 *generalized staff nurses* in departments of education, the median salary was \$1,763. The median salary for school nurses was \$1,764 as published by the National Education Association of the United States in a study of salaries of city school employees in cities of over 100,000 population, for the year 1940-41. This study was reviewed in the *Monthly Labor Review*.<sup>\*</sup> The median for head nurses' salaries in the N.E.A. study was \$2,050. In the N.O.P.H.N. sample, 63.2 percent of the nurses were paid on the 10-month school year basis. The median yearly salary for nurses paid on this basis was \$1,761, or stated as a monthly median salary, \$176. This figure is to be compared with \$134 for the staff nurse in the nonofficial agency, \$157 in the municipal health department, and \$135 in the county health department. Nurses employed on staffs of 50 and more received higher salaries than those on smaller staffs as measured by the median of \$1,985 among 287 such nurses. In departments of this size salaries clustered in the \$1,900 to \$2,300 groups, with 58.9 percent of all these nurses earning these amounts. Fourteen nurses on large staffs, however, earned less than \$1,200. All of these nurses were employed by one department of education in a Middle Atlantic state.

Among the 44 school nurses on one-nurse staffs, the median salary was \$1,692. None earned more than \$2,400. The highest salary was \$2,300, and the lowest was \$1,000.

The range of salaries among 42 *specialized*

<sup>\*</sup>"Salaries of School Employees, 1940-41." *Monthly Labor Review*, June 1941, p. 1544.

TABLE V  
NURSES IN SAMPLE OF 156 DEPARTMENTS OF EDUCATION BY SIZE OF EMPLOYING AGENCY AND POSITION ON THE STAFF

Size of employing agency	Total nurses in sample	Position on staff		
		Supervisors and assistant supervisors	Generalized staff nurses <sup>1</sup>	Specialized staff nurses <sup>2</sup>
Total nurses on staff	1,237	64	1,131	42
100 and over	....	....	....	....
50-99	309	11	287	11
25-49	248	10	233	5
15-24	225	7	206	12
10-14	65	4	57	4
5-9	199	11	180	8
2-4	147	21	124	2
1	44	....	44	....

<sup>1</sup> A generalized school nurse is one who is responsible for all phases of the school nursing program.

<sup>2</sup> A specialized school nurse is one who carries only one phase of the school nursing program, such as orthopedic work, audiometer testing, or clinic service.

TABLE VI  
NURSES IN SAMPLE OF 15 COMBINATION AGENCIES BY SIZE OF EMPLOYING AGENCY  
AND POSITION ON STAFF.

Size of employing agency	Total nurses in sample	Position on staff					
		Director and assistant director	Educa- tional director	General- ized supervisor	Special- ized supervisor	General- ized staff nurse	Special- ized staff nurse
Total nurses on staff	198	20	3	7	8	147	13
100 and over	....	....	....	....	....	....	....
50-99	....	....	....	....	....	....	....
25-49	90	6	3	5	7	63	6
15-24	32	3	....	1	....	27	1
10-14	34	5	....	....	1	27	1
5- 9	41	6	....	1	....	29	5
2- 4	....	....	....	....	....	....	....
1	1	....	....	....	....	1	....

*school nurses* was interesting. The highest paid was a nurse-teacher of health and home nursing who received \$4,000, and the lowest paid received only \$630 for audiometer work. The figures for the salaries of the other 40 are scattered. The median is \$1,820. It is evident that the responsibilities of these specialized school nurses vary widely.

#### BY LOCATION AND POSITION ON STAFF

When the salaries of *supervisors* in school nursing are reviewed as to parts of the country, it is evident that the Middle Atlantic and Pacific Coast departments pay more for such work than do other parts of the country. Six of the eight school nurse supervisors receiving \$3,000 and more are in these states.

The salaries of *staff nurses* in schools are highest in the Pacific states, as measured by the median of \$2,144 as compared with \$1,763 for the entire sample. Among the 25 school nurses in the Mountain states, the median salary was \$2,068. The range of school nursing salaries in the New England and Middle Atlantic states is of interest. Among 121 school nurses in New England, 2 school nurses received less than \$1,200 a year and only 1 received more than \$2,040. Among 317 school nurses in the Middle Atlantic states, 17 received less than \$1,200 and 66 received \$2,040 or more. Among 122 school nurses in the Southern states, the median salary was \$1,356, again a figure below the median for the entire sample.

It is of interest that 23 of the 42 *specialized school nurses* were employed in 8 school systems in the Middle Atlantic states. Among these 23, there was a wide range of salaries, three receiving less than \$1,200 a year, and 4 receiving \$3,000 or more.

#### 4. SALARIES IN COMBINATION AGENCIES

There were only 15 combination\* agencies in the 1942 sample. Table VI shows the number of nurses by size of agency according to position on staff.

##### BY SIZE OF AGENCY AND POSITION ON STAFF

The largest of the 15 combination agencies employed 36 nurses. There was 1 such agency in which the nurse worked alone. The salaries of the 20 nurses classified as *director* varied according to size of agency. The highest paid received \$300 as director of a 28-nurse agency, and the lowest paid received \$131 as director of a 9-nurse agency.

Three *educational directors* were employed in these combination agencies, all three working in agencies of over 25 nurses. The salaries varied from \$160 to \$200. In nonofficial agencies of similar size, the salaries of educational directors were higher, the median salary for 9 such workers being \$210.

Seven *generalized supervisors* and 8 *specialized supervisors* were employed by the 15 agencies. The middle salary for the generalized supervisors was \$183, and for the specialized, \$155.

Among the 147 *generalized staff nurses* the median salary was \$145. This may be compared with \$134 as the median among staff nurses in nonofficial agencies and \$157 among staff nurses in municipal health departments. The nurse working alone received only \$125, as compared with \$153 as the median for one-

\*For definition and discussion of combination agency, see "Going Forth" by Louise Hopwood, PUBLIC HEALTH NURSING, November 1939, p. 624.

nurse agency salaries in nonofficial agencies.

Among the 13 *specialized staff nurses* the middle salary was \$153, somewhat higher than the salaries for the *generalized staff nurse*.

#### BY LOCATION AND POSITION ON STAFF

The 15 combination agencies were located in widely scattered parts of the country. The Public Health Nursing Department of the Palama Settlement in Honolulu, working as an auxiliary of the Territorial Board of Health Public Health Nursing Bureau, was also classified as a combination agency in this review. Five of these agencies were in the Pacific states, 1 in the Southern, 6 in the Middle West, and 7 in the New England and Middle Atlantic states. The larger agencies were located in the Eastern part of the country, and therefore, the salaries of the *directors* were higher in these sections.

The highest salary paid a *generalized supervisor*, \$190, was paid to a nurse in Honolulu. The lowest salary, \$160, among the 7 was paid to a nurse in Pennsylvania.

The highest salary paid a *specialized supervisor* was \$175 paid to a nurse in Ohio, and the lowest salary was \$140.

Salaries of *generalized staff nurses* were higher among the nurses in the Pacific states and in the East North Central states than for other parts of the country. Salaries in Honolulu were also above the median of \$145.

In New England the 5 *specialized staff nurses* received less than \$130. These five nurses were employed by 1 agency in New England. Their work was tuberculosis and school service.

#### 5. SALARIES IN STATE DEPARTMENTS OF HEALTH

As already stated (p. 690), salaries of public health nurses paid entirely by state health departments were discussed in an earlier report.

#### 6. SALARIES IN WELFARE AGENCIES

There were 41 nurses in the 1942 sample that were employed by 6 official state crippled children's services, and 1 city welfare department. The 6 state departments employed 38 nurses.

The city agency employed 3 nurses to give service to relief clients in an eastern city of

about 30,000 population. The highest salary in the state crippled children's services was \$225 in a West North Central state, paid to a specialized supervisor in orthopedic nursing and physiotherapy. The lowest salary was \$125 a month, paid to nurses in a South Atlantic state. The median for all 38 nurses in these state crippled children's services was \$157. Salaries in the city department of public welfare were low. The director received \$125 and the two staff nurses, \$95. This agency was in the Middle Atlantic states, in which the median salary for municipal health department generalized staff nurses, in agencies of 3 nurses, was \$149.

#### 7. SALARIES IN TERRITORIAL AGENCIES

Two interesting schedules were received from outlying sections of the United States—The Territorial Department of Health of Alaska and The Insular Health Department of Puerto Rico. The lowest staff nurse salary in Alaska was \$185, and the highest, \$205. Less than 1 percent of the generalized staff nurses in state health departments received \$180 or more. The salaries in Puerto Rico were very low. Of the total 349 nurses, 154 received less than \$70; 158 received from \$70-\$99; and only 37 received \$100 or more. On this staff of 349, there was 1 director, 8 generalized supervisors, 3 specialized supervisors, 185 generalized staff nurses and 152 specialized staff nurses. There were also 10 non-nurse nutritionists whose salaries ranged from \$83 to \$125.

#### CONCLUSION

The N.O.P.H.N. appreciates the contributions of information from the 687 public health nursing agencies that make possible this report. The data are particularly useful at this time since salaries of all kinds are under scrutiny. The concluding table shows comparisons by the use of medians. It must be emphasized again that it is not desirable to try to standardize salaries by these medians. Our main purpose in presenting this table is to give a brief summary of the salaries for various positions in public health nursing. Detailed comparisons and ranges of salaries are available and will be sent upon request.



TABLE VII  
MEDIAN SALARIES<sup>1</sup> OF PUBLIC HEALTH NURSES BY SIZE OF STAFF AND TYPE OF AGENCY, SAMPLE OF JANUARY 1962

By size of staff	Nonofficial agencies			Municipal health departments			County health departments			Departments of education	
	Directors	General- ized supervisors	General- ized staff nurse	Directors	General- ized supervisors	General- ized staff nurse	Directors	General- ized supervisors	General- ized staff nurse	Supervisors and assistant supervisors	General- ized staff nurse
Total, agencies all sizes	\$221	\$167	\$134	\$208	\$207	\$157	\$178	\$164	\$135	\$2,187	\$1,763
In agencies employing 100 nurses or more	417 <sup>2</sup>	168	138	254	211	170	....	....	....	....	....
50-99 nurses	344	177	138	229	172	155	.... <sup>3</sup>	182	132	2,280	1,985
25-49 nurses	260	163	132	221	175	116	250 <sup>2</sup>	208	156	2,588	1,768
15-24 nurses	260	163	127	222	170	133	200	170	130	2,120	1,564
10-14 nurses	219	163	132	192 <sup>2</sup>	168	135	177	163	131	2,300 <sup>2</sup>	1,770
5-9 nurses	202	168	127	178 <sup>2</sup>	168 <sup>2</sup>	146	175 <sup>2</sup>	160	134	2,280	1,670
2-4 nurses	179	164	130	165	....	149	135 <sup>2</sup>	160 <sup>2</sup>	134	1,992	1,558
1 nurse	....	....	153	....	....	142 <sup>2</sup>	....	....	150	....	1,692

<sup>1</sup> For nurses in the 253 nonofficial agencies, the 94 municipal health departments, 118 county health departments, the median monthly salary is given. For nurses in the 156 departments of education, the median yearly salary is given.

<sup>2</sup> Actual salary of middle person used because sample is small.

<sup>3</sup> Salaries of only 2 directors reported in this group, \$242 and \$267.

## NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

### BOARD AND COUNCIL MEETINGS

January 20 will mark the beginning of the annual meetings of the three national nursing organizations in New York City. The N.O.P.H.N. Council of Branches will meet all day on Thursday, January 21; the N.O.P.H.N. Board of Directors all day Friday; the joint boards of the three organizations on Saturday.

### FIELD SERVICE

FOLLOWING considerable travel on the part of the N.O.P.H.N. staff during October, November found most of them "close to home."

In New York, during the Annual Graduate Fortnight of the New York Academy of Medicine, October 7-23, Mary M. Macdonald assisted with a series of demonstrations of the Kenny Method in connection with presentations by several physicians of principles and symptomatology of the Kenny concept of infantile paralysis.

Field service outside of New York included:

On November 7 at the St. Charles Hospital, Port Jefferson, Long Island, Miss Macdonald assisted Dr. Richard Kovacs, consulting physical therapist, with a demonstration of the Kenny Method. At the request of Dr. Philip M. Stimson, former medical director of the Willard Parker Hospital, New York, N.Y., on November 18, Miss Macdonald assisted at a demonstration of the Kenny treatment of infantile paralysis at a meeting of the Middlesex County Medical Society at Perth Amboy, New Jersey.

Bethel J. McGrath, industrial consultant, traveled somewhat farther afield. From the thirtieth of October to November 8 she visited Minneapolis, Minnesota, where she attended meetings of the Minnesota League of Nursing Education

and the Industrial Nursing Section of the Minnesota S.O.P.H.N., of which she is chairman. From November 10-13 she visited Syracuse, New York, where she lectured on industrial nursing at Syracuse University. She also observed nursing in industries in that vicinity.

### EVELYN DAVIS RESIGNS

THE NEWS that Evelyn K. Davis has resigned from the staff of the N.O.P.H.N. will be a source of regret to many. During a year's leave of absence she has served as regional field worker in the recruitment and training of volunteers in the Office of Civilian Defense and will continue to mobilize citizen interest in civilian defense and community health and welfare activities for the regional office of OCD in the First Civilian Defense Area, with headquarters in Boston, Massachusetts, at 17 Court Street. When Miss Davis came to the National Organization in 1929 as assistant director and secretary of the Board and Committee Members' Section it was to fill a newly created position. The idea of stimulating lay interest in public health nursing was comparatively new. Although many progressive boards of directors of nursing agencies were achieving splendid results in their own communities, Miss Davis helped them to extend their interest into state and national fields. She did much to promote the development of citizen advisory committees for official as well as voluntary committees. Her publications in this field have included "A Training Course for Volunteers in the Public Health Nursing Field," "A Study of Volunteer Services," and her recent handbook, "The Volunteer in Public Health Nursing," which is being widely distributed by the N.O.P.H.N.

During her extensive association with boards of directors and committees of public health nursing agencies, her unusual ability to work with other people added to her understanding of their points of view after long training and experience helped in making organization adjustments which have strengthened public health nursing in many communities. One of the by-products of this field service which extended into all but four of the states was to make the N.O.P.H.N. services widely known.

The many lay people, volunteers, citizens, board members—call them what you will—who have benefited from the help and advice Evelyn Davis has been able to give while on the staff of the N.O.P.H.N. will be glad to know that she will still work with volunteers. In her choice to continue her work in this field, it is with the strong conviction that democracy can be more than a theory, can become an actively working philosophy if citizens know their own communities—the needs and services, know how they tie in with civilian protection against war, know that a special philanthropic interest is only part of the whole effort it takes to make a better community, a fuller life for all. Our deeply sincere wishes are for success and lasting friendship with the unending stream of loyal board members.

LYDIA B. STOKES, *Chairman*  
*Board and Committee Members' Section*

#### NEW SECTION SECRETARY

EDITH MCCARTHY WENSLEY becomes the new secretary of the Board and Committee Members' Section in place of Evelyn Davis. Mrs. Wensley graduated from Radcliffe (cum laude and a member of Phi Beta Kappa—she says, don't mention it), and subsequently spent a number of years at newspaper, publicity, and public relations work. She was a reporter on the *Boston Globe*, was later publicity and financial secretary of the Community Health Association in Bos-



Edith M. Wensley

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ton. While in this organization she served also as consultant editor of the *Bulletin* of the Boston Council of Social Agencies, and represented the agency on the Boston Community Fund. More recently Mrs. Wensley has been active in volunteer work in hospitals, in clubwork as publicity chairman of Radcliffe Club of Westchester, and in numerous wartime activities. N.O.P.H.N. considers itself fortunate to have secured the services of one not only possessed with ability and skill, but with a gay and dynamic personality—and may we add with an authentic Boston accent.

#### NEW N.O.P.H.N. REPRINT

A REPRINT of "Maintaining Minimum Public Health Nursing in Wartime," which appears on page 659 in this issue, may be obtained by any public health nursing agency from the National Nursing Council for War Service free of charge. The Council will distribute a limited number of copies in connection with the new "Priorities for Nurses"—a revision of "Nurses, to the Colors!"—which is now on the press.

## COMMITTEES OF THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, 1942-1944\*

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(See adv. page 2, this issue)

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\*Marion G. Howell, president, and Ruth Houlton, general director, are *ex officio* members of all committees. Mary Edwards Shaw, editor of PUBLIC HEALTH NURSING, may attend any meeting of any committee upon request.

**Note:** For list of members of Publications Committee see adv. page 2.

For list of members of Nominating Committee see July issue, page 344.



## Reviews and Book Notes

### THE MODERN ATTACK ON TUBERCULOSIS

By Henry D. Chadwick, M.D., and Alton S. Pope, M.D. 95 pp. The Commonwealth Fund, New York, 1942. \$1.

Health officers and administrators of tuberculosis control programs will find this concise authoritative handbook a convenient and invaluable guide. The essentials of an effective control program are briefly but clearly stated, and the authors leave no doubt regarding the responsibility of departments of health in this regard. A point well emphasized is the desirability of handling tuberculosis simply as one of the communicable diseases and not as an isolated problem. Sound diagnostic procedures and essentials for effective treatment are discussed with brevity and directness. The changing picture in epidemiological aspects indicates a point of departure for a planned control program, and guidance in the operation of such programs is presented in the discussion of case-finding procedures and the outline for a community campaign.

This book has value for all physicians in their daily practice and as an indicator of their responsibility in the control of tuberculosis. Public health nurses also will find this presentation of the tuberculosis problem an easy and helpful reference.

GERTRUDE TOUCHTON, R.N.  
*New Haven, Connecticut*

### THE PEOPLE AGAINST TUBERCULOSIS

By Leigh Mitchell Hodges. 54 pp. National Tuberculosis Association, 1790 Broadway, New York, 1942. \$1.

The word-wizardry of the experienced columnist plus the enthusiasm of a campaigning evangelist make this a fascinating story. A bit of indifference and hard-boiledness creeps into the soul of the professional tuberculosis worker to whom, nowadays, Christmas Seals repre-

sent a highly-organized sales campaign. The human side of the problem tends to become sob stuff. The same can be true of the public health nurse, who may have nothing to do with selling Christmas Seals, and finds that the hard work of her assignment steals away the thrill of achievement which should be hers. The very fact that she is there, as part of the community public health program, is a big story.

All this is part of the story which Mr. Hodges has written into his book. He has cleverly intertwined historical facts about the scientific work of Koch, Laennec, Roentgen, Trudeau, Biggs, and others, in his account. But his main theme is the rise of public awareness of the people's own stake in the fight. In this, he ascribes a major role to the Christmas Seal. Those who thought of and made the Seal potent—Einar Holboll, Jacob Riis, Emily Bissell, the newspaper men—are the heroes of this drama.

The book is 64 pages of excellent writing, beautifully printed and illustrated.

ROWAN WHEALDON  
*Newark, New Jersey*

### POSTURE AND NURSING

By Jessie L. Stevenson, R.N. 63 pp. Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York, 1942. Free.

This attractive handbook is one of a series in orthopedic nursing planned by the Joint Orthopedic Nursing Advisory Service. Nurses, particularly those who are providing nursing care to patients with orthopedic problems, will find this work most useful. With a minimum of emphasis on the negative or correctional point of view, it stresses the positive or preventive approach to orthopedic conditions. Great care and clearness is

(Continued on advertising page 12)

# NEWS

## *Highlights on Wartime Nursing*

### NEW ARMY REGULATIONS

ACCORDING TO War Department Circular No. 365, dated November 5, 1942, married nurses are eligible for assignment to the Army Nurse Corps. They must be under 40 years of age, have no minor dependents for whom adequate provision cannot be made, be willing to serve wherever assigned and for the duration plus six months. How much this regulation will increase the number of nurses eligible for service is not known definitely. There are about 16,000 married nurses under 40 in the Second Reserve of the Red Cross Nursing Service, but they have not yet had time to indicate their availability. Since this regulation became effective, married nurses have not made inquiry about service in any appreciable numbers.

Effective October 1, 1942, a member of the Army Nurse Corps who marries will be continued in active service for the duration of the present emergency and six months thereafter, or until found physically, or otherwise, disqualified for further active military duty. This will reduce materially the turn-over in the Corps, a large percent of which has been due to marriage. Although the large majority of nurses assigned to the Army Nurse Corps during this war have been referred to it by the American Red Cross, the Surgeon General of the Army has asked that from now on all applicants for assignment to the Army Nurse Corps be approved by the American Red Cross, regardless of whether they apply directly to the Army or the American Red Cross. The American Red Cross will, therefore, hereafter evaluate the credentials of all nurses seeking assignment with the Army Nurse Corps to determine their professional eligibility for Army service.

### DISTRIBUTION AND RECRUITMENT

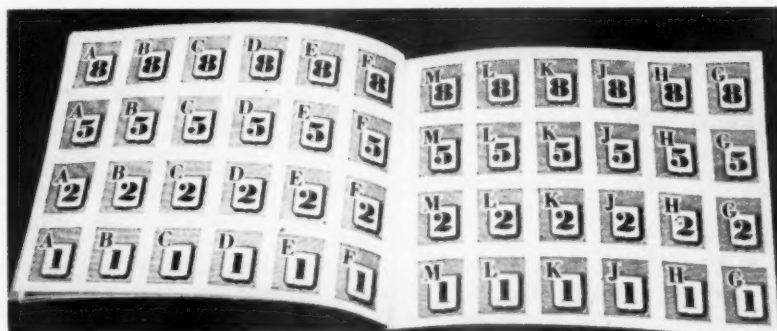
THE NATIONAL Nursing Council for War Service has revised its enrollment flier, "Nurses to the Colors!" under the new title "Priorities for Nurses." The new version will include five inserts—one on public health nurses prepared by the N.O.P.H.N., one on institutional nurses by N.L.N.E., and three by the A.N.A., on private duty nurses, general staff nurses, and office nurses. The Supply and Distribution Committee compiled the revision and it is available free of charge from the Council, 1790 Broadway, New York, N.Y.

Through the Office of War Information the week of December 7-14 will be set aside for an intensive radio campaign to recruit student nurses. Kits prepared by the Subcommittee on Nursing and the Council will be issued through the Federal Security Agency to national and local radio outlets for use at this time. This is a special drive for 18,000 students to enter schools of nursing in the spring.

County public health nurses are proving helpful in distributing the U. S. Public Health Service poster, "Become a Nurse," and promoting recruitment in high schools, particularly in rural areas. They reach a territory that many other nurses cannot possibly cover.

The U. S. Office of Education has prepared a new pamphlet, "Professional Nurses Are Needed," and loan kits containing 15-minute recordings on nursing, and program suggestions on recruitment for use in connection with the nursing program of the High School Victory Corps.

The Council's new bulletin, "More Students—How Schools of Nursing Can Recruit Them," is ready and available upon request.



Pages from War Ration Book Two

OWI photo

### FAMILY FOOD BUYING

TOWARD THE end of this year everyone in the United States will receive War Ration Book Two, is the recent announcement of the Office of Price Administration to a number of cooperating national groups, of which the N.O.P.H.N. is one. This ration book will be used to secure goods that will be rationed under the "point system." It will relate to certain new rationing programs and will not replace the straight coupon rationing of sugar, gasoline, and coffee already in force. What new groups of commodities are to be rationed under the "point system" will not be announced until just before the specific rationing goes into effect. This preliminary report is made to public health nurses, however, because as family teachers they are going to have a lot to do with explaining the operation of "point rationing" to the families in their care. Much more information will be made available to nurses later on this subject through the N.O.P.H.N. as well as through usual public information sources.

Briefly, "point rationing" means that certain groups of scarce commodities will be rationed by "points" in order that available supplies will have a fair distribution among all the people. When the consumer buys a point-rationed food he will pay not only cash according to already established ceiling prices, but he will also surrender stamps out of his War Ration Book Two equivalent to the total

point value fixed for the particular food. Lists of point values will be widely advertised at the proper time. Thus the public health nurse must not only help explain how stamps plus money are exchanged for desired commodities, but she will need to know about the nice relation which will come into existence between cost of food, family allotment of "points," and relative nutritional values.

A page of stamps from the new book is shown on this page. The numbers on the stamps are the "points," the letters signify the time period when the stamps may be used. Thus points on A stamps add up to 16. A, B, and C might represent a month's supply, or a total of 48 points.

### ACCELERATION OF NURSING EDUCATION

"NURSING EDUCATION IN WARTIME" is the title of a new series of bulletins to be issued by the N.L.N.E.'s Committee on Educational Problems in Wartime. Bulletin No. 1, just received, contains general recommendations for acceleration of the organized instruction of the basic professional program according to three plans: (1) a three-year program condensing all essential instruction and experience into 30 months, with the last six months devoted to additional supervised nursing practice in any clinical division where such service is needed (2) a 28-months' program for students

with two or more years of college who are qualified for nursing by aptitude and demonstrated ability—to be graduated at the end of the period, state law permitting (3) a 24-months' plan for mature college graduates, qualified for nursing both by aptitude and demonstrated ability—to be graduated after the 24 months, state law permitting. Arrangement of programs under the three plans is shown in some detail. Flexibility in their use is emphasized as essential. A limited number of copies of the bulletin are available at 10 cents each from the League, 1790 Broadway, New York, New York.

#### APPEAL FOR TOTAL PHYSICAL FITNESS

In June 1942, some 8500 key executives in war production plants received a letter from the President, transmitted to them by Paul V. McNutt, chairman of the War Manpower Commission, calling for active encouragement of physical and moral fitness. The President said:

I have reports of the recent meeting between the United States Public Health Service and the War Production Board looking to a vigorous emphasis on industrial hygiene and health education in the current war production drive. Co-operation of the Public Health

(Continued on advertising page 9)

### *From Far and Near*

• The following are the newly elected officers of the California State Organization for Public Health Nursing:

President—Olivia Hunsinger, Pittsburg  
 First Vice-President—Irene Carlson, San Francisco  
 Second Vice-President—Margaret Cree, San Francisco  
 Secretary—Virginia Platt, San Francisco  
 Treasurer—Mrs. Phebe Kirby, Santa Cruz  
 Nurse Directors—Rena Haig, San Francisco;  
 Rosemary Kobes, San Francisco  
 Lay Directors—Mrs. Gerrard January, San Francisco; Mrs. Fredrick Williamson, Pasadena

• New officers of the Minnesota S.O.P.H.N. are as follows:

President—Ann Nyquist, Minneapolis  
 Vice-President—Catherine Vavra, Duluth  
 Secretary—Mrs. Frances Shelly, Minneapolis  
 Treasurer—Sanfred C. Gustafson, Hopkins

• Get your prize poem into Harbinger House, 381 Fourth Avenue, New York, N.Y., before January 15, 1943. This annual poetry contest for nurses, selected poems to be published under the title, "Songs of the Nightingale," carries with it prizes in cash and books. The editors of Harbinger House will send further information and rules upon request.

#### *Physical Condition of Low-Income Youth:*

That nine-tenths of the young people between 16 and 24 in low-income families are in need of medical or dental care is revealed by a recent study\* made jointly by the U. S. Public Health Service and the National Youth Administration. Although two-thirds of these young people are physically fit for any kind of work, one-third of them are limited by health defects in the work they can do. The findings are based upon some 150,000 complete physical examinations of out-of-school youth on work programs of the National Youth Administration. This group of young people is believed to be representative of approximately 12 million American youths from low-income families.

The physical examinations were made by local physicians and dentists and included an evaluation of each youth's employability in terms of his health status. Untreated dental caries was recorded for 83 percent of the individuals who were examined by a dentist, with about 5 defective teeth per person. Over one-third had defective vision, for the most part slight. More than one in 10 were 15 percent or more below the average weight for their age, sex, and height; over 5 percent weighed 25 percent or more above average.

\*"The Health Status of National Youth Administration Youth on Out-of-School Work Programs—A Nation-wide Study." (In press, Government Printing Office, Washington, D.C.)

**Merchant Marine Ashore:** The United Seamen's Service, Inc., under the auspices of the War Shipping Administration, provides clubs, rest and recuperation centers for men and officers of the merchant marine. An important part of the program, and one which will interest public health nurses, is the plan for provision of medical and welfare service to men "who have endured the rigors of life on rafts and open boats, to those who have been fished out of the ocean, rescued from burning oil, and other convoy casualties, sufferers from torpedoes, mines, airplane bombings and machine gunnings"—in the words of U. S. S. Douglas P. Falconer, former executive director of the Greater New York Fund, is national executive director.

**On War Basis:** Because of wartime conditions the National Conference of Social Work will, in 1943, hold three—possibly four—regional meetings instead of one national annual meeting. The schedule is: New York City—March 8-12; St. Louis—April 12-16; Cleveland—May 24-28; Pacific Coast (if held)—late June.

**Kenny Method Courses:** Aided by the National Foundation for Infantile Paralysis, teaching programs in the Kenny method are now conducted at six centers, and information as to costs, dates, and admission policies can be secured directly from these schools and universities: Stanford University, California; University of Southern California, Los Angeles; University of Minnesota, Minneapolis; Northwestern University Medical School, Chicago; D. T. Watson School of Physiotherapy, Leetsdale, Pennsylvania; Physical Therapy Post-Graduate School, Georgia Warm Springs Foundation.

Plans are under way to add a seventh training center in New York City opening perhaps in December. The Foundation's October *News* warns: "To prepare a nurse to carry on muscle re-education calls for at least six months of training. It would seem to be wiser for those communities without physical therapy technicians to consider sending a nurse to a school of physical therapy. These courses take one full academic year and provide not only training in all aspects of the Kenny method but

(Continued on advertising page 10)

### TIP FOR NEW FATHERS

**T**HIS POSTCARD was sent by the San Francisco Visiting Nurse Association to all fathers of birth registrants published in the San Francisco papers. The agency's service to mothers of young babies increased by leaps and bounds.



### A NURSE FOR THE PRICE OF A DOZEN ROSES!

For \$1.50 you can buy your wife the most thoughtful of presents---infant care instruction from a graduate, registered nurse.

To overcome that helpless feeling new mothers as well as new fathers often have, the Visiting Nurse will demonstrate the baby's bath, the formula, and interpret the doctor's instructions.

Learn how you can do your wife and baby this favor.

**CALL:** The Visiting Nurse Association  
1636 Bush St. ORday 9100

**SPECIAL ADJUSTMENTS ARE MADE FOR THOSE WHO CANNOT PAY THE FULL FEE.**



### British Nursing

*(Continued from page 689)*

war it has seemed wise to change the ruling against the admission of married nurses to these services. It has also been found advisable to increase the age limit, which used to be not over 35 years on admission, to 45 years. Auxiliary nurses are also employed for hospital ward work by the Army but they do not hold rank. At the present time they are in the process of changing this status and very soon I believe all the V.A.D.'s will be members of the women's services (the A.T.S., W.R.N.S., or W.A.A.F.) rather than remain in the Red Cross or St. John's Ambulance Brigade as heretofore. This change will not affect the status of the V.A.D.'s in civilian hospitals. Nurses connected with the Royal Air Force do not serve in air ambulances and are not trained in parachute jumping. Those in the Navy serve only ashore. Sick birth ratings (male orderlies) perform nursing duties afloat.

Postgraduate educational programs

and professional meetings are still being carried on, and despite the great difficulties of war travel, they are very well attended. The Royal College of Nursing is still very active in its central office in London as well as in its many branches throughout the country. The professional magazines are being published despite the terrific shortage of paper and they still contain many pictures. This is possible only because the Government is willing to release supplies of its precious film for educational purposes. In fact, a sign has been put on the door of British nursing, "Business as Usual." Nevertheless, as one reads it he cannot help but agree with the little shopkeeper who, after seeing that statement on the doorfronts of all of his neighbors, changed his own placard to read, "There is no such thing as business as usual but we manage to carry on."

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From notes of a lecture given by Miss Phillips in the course, "International Aspects of Nursing," at Teachers College, Columbia University, October 8.

### PUBLICITY MATERIAL WANTED

The N.O.P.H.N.'s plan for keeping the loan folders on publicity materials up to date is to revise them once a year. This means that by January 1, the loan folders on Exhibits, Newspapers and Periodicals, Plays (demonstrating group instruction, history and organization of public health nursing, resources and relationships, services to public health nursing), Printed Material, and Radio should contain new material which local agencies have used during the past year. Will you please send us any new posters, leaflets, or other printed material which you have used effectively during the past winter, as well as pictures and description of window exhibits?

We should also like to have good plays and radio talks. More and more local organizations are using the dramatic presentation of public health nursing, and there are many requests for plays showing nursing service—such as the health-education visit, school inspection, visiting-nurse service, or mothers' club. Talks, dialogues, and dramatic material for the radio seem to be constantly in demand. Will you please share with us and others copies of whatever material you have? The loan folders may be borrowed by N.O.P.H.N. members for the cost of mailing, and by others at a charge of 50 cents for two weeks.

## NURSE PLACEMENT SERVICE



announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

## PLACEMENTS

- \*Alice F. Malcolm, assistant director, Toledo District Nurse Association, Toledo, Ohio.
- \*Anna C. Myers, health unit supervisor, Illinois State Department of Health, Springfield, Ill.
- \*Mrs. Isabel C. White, supervisor of out-patient clinic, Parkland Hospital School of Nursing, Dallas, Tex.
- \*Mrs. Carolyne H. Reed, community nurse, Consolidated Health District, Canton, N.Y.
- \*Vivian R. Smith, public health nurse, Consolidated Coal Company, Jenkins, Ky.
- Irma L. Brunelle, school nurse, Lawrenceville School System, Lawrenceville, Ill.
- H. Virginia MacIntosh, school nurse, Amarillo Public Schools, Amarillo, Tex.
- Agnes B. Smith, school nurse, County of Shoshone, Wallace, Idaho.
- Mrs. Ruby Rich Bugar, assistant college

- nurse, Occidental College, Los Angeles, Calif.
- Frances G. Adcock, boys' club nurse, Union League Boys' Club, Chicago, Ill.
- Mrs. Grace Erickson, temporary industrial nurse, Montgomery Ward & Company, Chicago, Ill.
- Mildred Mae Gross, industrial nurse, Cribben & Sexton Company, Chicago, Ill.
- Mrs. Elaine M. Logan, industrial nurse, Union Special Machine Company, Chicago, Ill.
- Mrs. Elsie C. Moore, industrial nurse, Chicago Metal Hose Corporation, Maywood, Ill.

## ASSISTED PLACEMENTS

- \*Patricia Walsh, supervisor, Michigan Department of Health, Lansing, Mich.
- \*Kathleen H. Sheehy, supervising nurse, Marin County Chapter, Visiting Nurse Service, San Rafael, Calif.
- \*Mrs. Marjorie E. Little, public health nurse of Grant County, State Department of Health, Santa Fe, N.Mex.
- \*Eleanor Lorenz, public health nurse of Hidalgo County, State Department of Public Health, Santa Fe, N.Mex.
- Marjorie Louise Anderson, staff nurse, Visiting Nurse Association, Evanston, Ill.

\*The N.O.P.H.N. files show that this nurse is a 1942 member.

## THE AMERICAN JOURNAL OF NURSING FOR DECEMBER

## On Going Into the Army

- |  |   |
|--|---|
| Epilepsy.....  | G. J. Doolittle, M.D., Vivian S. Green, R.N., and Sarah Vallone, R.N. |
| Health Program for Defense Workers.....                      | Lucile B. Graves, R.N.  |
| The Menopause.....   | August A. Werner, M.D.  |
| Training Flyers for High Altitudes.....                      | Esther M. Binder, R.N.  |
| The Community Lends Its Help.....                            |   |
| An Oxygen Tent for the Premature.....                        | Marguerite Heinz, R.N.  |
| Private Duty Nursing in War-Time.....                        |   |
| Our War Nursing Program.....                                 | Alma C. Haupt, R.N.   |
| A State-wide Refresher Program.....                          | Thelma T. Brewington, R.N.  |
| Strains and Hernia.....                                      | Harvey Bartle, M.D.   |
| The Chemistry Course.....                                    | Louise M. Schmitt, R.N., and Helen I. Miner, R.N.                     |
| A Psychiatric Nursing Affiliation.....                       |   |
| Transurethral Prostatectomy.....                             | Audrey Jane Barrett, R.N.   |
| Application of the Principles of Learning.....               | Ellen L. Buell, R.N.  |
| Entering Students vs. College Freshmen.....                  | Alice McWilliams, R.N., and H. Phoebe Gordon                          |
| Refresher Courses.....                                       |   |
| A Ward Teaching Program.....                                 | Margaret Perry, R.N.  |
| The War Conference of the American Hospital Association..... |   |

# PUBLIC HEALTH NURSING

DEC 31 1942

DECEMBER 1942

MAINTAINING MINIMUMS  
IN  
PUBLIC HEALTH NURSING

WARM CLIMATE DISEASES

ERNEST C. FAUST, PH.D.

NURSES' SALARIES:  
1942 REVIEW

NUTRITION IN  
TUBERCULOSIS

HORACE R. GETZ, M.D.

YOUNG WORKER

WILLIAM M. SCHMIDT, M.D.

VOLUNTEERS IN HEALTH

DOROTHEA C. WELLS

# AMERICA'S FLAVOR FAVORITES

made from WHOLE GRAIN or restored to  
whole grain nutritive values of  
Thiamin, Niacin and Iron

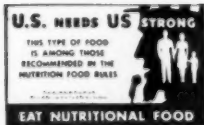
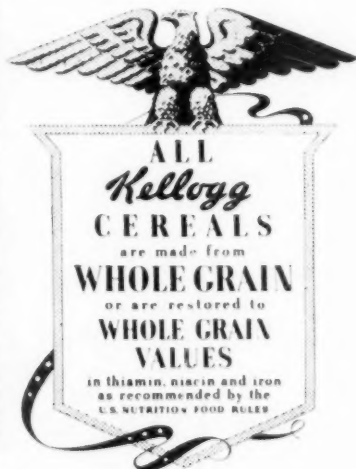
Take advantage of established  
eating habits to promote better nutrition



★ In considering your part in promoting the national nutrition program, remember these facts:

1. Every Kellogg Cereal is made of whole grain, or is restored to whole grain level of Thiamin (vitamin B<sub>1</sub>), Niacin, and Iron. Thus, every Kellogg Cereal meets the requirements of the U. S. Official Nutrition Food Rules.

2. Kellogg cereals have long been America's most popular ready-to-eat cereals. They are an established eating habit in every section of the country.



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## KELLOGG'S CEREALS

Made in Battle Creek

In responding to an advertisement say you saw it in Public Health Nursing

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# AMERICA'S FLAVOR FAVORITES

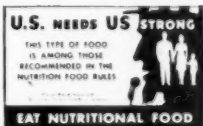
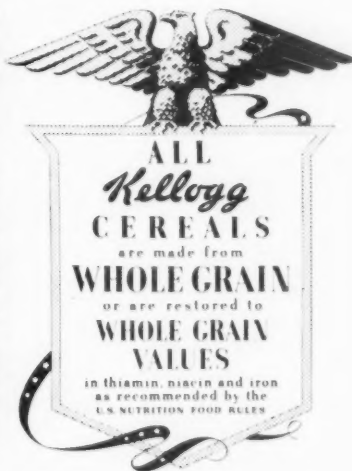
made from WHOLE GRAIN or restored to  
whole grain nutritive values of  
Thiamin, Niacin and Iron

Take advantage of established  
eating habits to promote better nutrition



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